



CALIFORNIA TRIBAL BEHAVIORAL RISK FACTOR SURVEY SUMMARY REPORT

2018-2019

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ACKNOWLEDGMENTS

The California Rural Indian Health Board, Inc. (CRIHB) California Tribal Epidemiology Center (CTEC), would like to thank all of those that participated in the California Tribal Behavioral Risk Factor Survey and shared their experiences. We thank all of you for your contribution and effort in aiding our work to improve health in Tribal communities located in California.

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Submit a data request through our website:

<https://crihb.org/technical-assistance-request-form/>

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CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

Dear Tribal Community Members,

The California Rural Indian Health Board, Inc. (CRIHB) California Tribal Epidemiology Center (CTEC) is one of 12 Tribal Epidemiology Centers funded by the Indian Health Service and the Centers for Disease Control and Prevention (CDC). CTEC works diligently to improve the health of American Indian and Alaska Natives (AIAN) in California by collecting and interpreting health information to establish health priorities, monitor health status, and develop effective public health services that respect the cultural values and traditions of Tribal communities.

CRIHB and CTEC are committed to the needs and interests that elevate and promote the health status and social conditions of the Indian people of California. In support of this mission, CTEC conducted the second California Tribal Behavioral Risk Factor Survey (BRFS) in an effort to increase the information available on the health risk behaviors that lead to mortality, morbidity, and social problems among AIAN adults 18 or older in California.

The California Tribal BRFS was adapted from the CDC Behavioral Risk Factor Surveillance System, a national survey of adults 18 or older, developed to collect data about health-related risk behaviors, chronic health conditions, and use of preventative services among adults. CTEC staff modified the California Tribal BRFS to be culturally sensitive and specific to Tribal communities in California. As a result, the survey is among the largest state-based samples of AIAN adults in the United States. A total of 2,209 California AIAN adults, ages 18-99, completed the California Tribal BRFS during the 2018–2019 data collection period.

AIANs are consistently underrepresented in local, state, and national data. It is significant to note that the California Tribal BRFS provides state and local level data for the AIAN adult population in California. Furthermore, the report aids in assessing the prevalence of health behaviors, monitoring progress toward achieving health objectives, developing disease prevention programs, and evaluating health policies and programs designed to decrease health risk behaviors and improve health outcomes among AIAN adults.

We are pleased to present this crucial report. Thank you to the hundreds of Tribal community members who participated in this important endeavor, as well as the CTEC Advisory Committee for supporting CRIHB and CTEC in this important work.

Sincerely,

A handwritten signature in blue ink, appearing to read "Mark LeBeau".

Mark LeBeau, PhD, MS
Chief Executive Officer
California Rural Indian Health Board, Inc.



EXECUTIVE SUMMARY

The California Tribal Behavioral Risk Factor Survey (TBRFS) was developed and implemented to aid the California Rural Indian Health Board, Inc. (CRIHB) California Tribal Epidemiology Center (CTEC) in assessing cultural connectedness, the prevalence of health behaviors, progress in achieving health objectives, development of disease prevention programs, evaluation of health policies and programs designed to decrease health risk behaviors, and health outcomes among the American Indian and Alaska Native (AIAN) population in California.

The TBRFS is based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The CDC BRFSS collects data on health-related risk behaviors, chronic conditions, and the use of preventative services. In addition to the CDC BRFSS questions, the TBRFS also includes culturally specific questions relevant to the AIAN population. The Tribally adapted survey instrument, sampling strategy, and recruitment plan were reviewed and approved by the CRIHB CTEC Advisory Council (AC). The AC comprises community and health professional representatives from universities and Tribal Health Programs (THPs).

As part of the eligibility criteria to participate in the TBRFS, respondents had to be at least 18 years of age, identify as AIAN, reside in California, give consent, and have not taken the survey before. The CRIHB CTEC staff administered the TBRFS from June 2018 to January 2019 at 41 rural and urban events (cultural gatherings, powwows, health fairs, and Tribal and Urban Indian Health Programs).

Results from this cross-sectional study showed that 2,209 AIAN adults completed the survey. Of the total respondents, 46.6% were between 18 and 40 years of age, 65.2% were female and 47.6% identified as AIAN only. Of those that identified with another race (in addition to AIAN), 62.6% were AIAN and White (non-Hispanic). Of the respondents, 48.6% were enrolled in a federally recognized Tribe in California. Approximately one-third of respondents were single and another one-third were married. Only 15.7% graduated from college or completed graduate school. Almost 50% were employed for wages. Twenty percent of respondents said they made less than \$10,000 a year and 12.5% said they made between \$35,000-\$49,000.

The health status analyses showed that almost thirty percent of the total survey population had not had a routine check-up in over a year. Less than five percent reported that their health status was poor. Approximately thirteen percent of respondents did not have health coverage. According to their body mass index, most respondents were either considered to be in the obese category (54.7%) or overweight (29.3%). Over half of the survey population for each type did not receive a flu vaccination, shingles, zoster, or pneumococcal vaccine. About half of the respondents had been tested for the human immunodeficiency virus (HIV), and almost all said they had not been treated for a sexually transmitted disease in the past year.

Respondents with high blood pressure were advised by their medical providers to change their lifestyles. These changes included altering their diets (69.7%) or taking medications (58.0%). About twenty percent of the respondents were diagnosed with diabetes by a health professional. Of those diagnosed with diabetes, about fifty percent were between 31 and 50 years of age when first diagnosed with diabetes.



The analysis showed that there was alcohol and drug use among the survey population. Almost 70% had an alcoholic drink in the past month. Among those, 37.8% binge drank. Among females, 35.2% binge drank (four or more drinks on a single occasion) in the past month. The percentage among males was 43.6% who binge drank (5 or more drinks on a single occasion). About one-fourth of the respondents reported using illegal or prescription drugs for non-medical reasons in the past year. Of those who reported using marijuana or hashish, almost half used it 16 days or more in the past 30 days. Of those that reported smoking, nearly one-third smoked every day and two-thirds tried to quit.

Spiritual and cultural connectedness analyses showed that 80.7% of all respondents planned to learn more about their culture and history. Most respondents agreed (72.5%) that they had spent time trying to learn more about being Native American/Indigenous, such as history, Tribal identity, traditions, language, and customs. Of the total respondents, 74.7% agreed they had a strong connection to their AIAN/Indigenous community or Tribe. Most of the respondents (75.8%) agreed they had a strong sense of belonging to their Native American/Indigenous community or Tribal Nation. Only 12.6% disagreed with the statement about belonging.

Results from the analyses showed that 62.8% of the total respondents said they did not always receive the social and emotional support they needed. Some of the common adverse childhood experiences (ACE) included past parent separation/divorce (experienced by 42.7% of respondents) and living with someone who abused alcohol (40.3%). Results also found that 47.5% experienced verbal abuse, with about one-fourth reporting sexual abuse.

A few caveats should be considered when reviewing the results of this report. Many respondents were recruited at AIAN community events or clinics, therefore, findings from the TBRFS may or may not be generalizable to those who do not attend these types of events. In addition, since all responses were self-reported, there may have been recall bias. Although the data needs to be more comprehensive in generalizability, it remains an important source of information on the health and well-being of the AIAN population in California.

Further studies should be conducted on chronic diseases, alcoholism, smoking, and ACE. Results from this report can be utilized by Tribes, THPs, and UIHPs to bolster advocacy and policy-making decisions, monitor progress toward achieving physical and mental health objectives and improve disease prevention programs to decrease health risk behaviors.





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INTRODUCTION

The California Rural Indian Health Board, Inc. (CRIHB) California Tribal Epidemiology Center (CTEC) works to improve American Indian Alaska Native (AIAN) health in California by engaging AIAN communities in collecting and interpreting health information to establish health priorities, monitor health status, and develop effective public health services that respect cultural values and traditions of the communities. In support of this mission, the CRIHB CTEC conducted the second California Tribal Behavioral Risk Factor Survey (TBRFS) in an effort to increase the information available on health risk behaviors, preventative health practices, health care access, and social determinants of health among California AIAN adults.

The TBRFS is based on the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The CDC BRFSS, a national telephone random-digit-dial survey, collects state data on health-related risk behaviors, chronic conditions, and the use of preventative services. The CDC BRFSS completes more than 400,000 adult interviews each year, providing a vast dataset on the health-related risk behaviors among adults in the United States.¹

As the AIAN population is often underrepresented at the local, state, and national level, the TBRFS was developed and implemented to aid CRIHB CTEC in assessing the prevalence of health behaviors; monitor and achieve health objectives; develop disease prevention programs; and evaluate health policies and programs designed to decrease health-risk behaviors and improve health outcomes among AIAN. In addition to health data, TBRFS also collects cultural information relevant to AIAN communities. The Tribally adapted survey instrument, sampling strategy, and recruitment plan were reviewed and approved by the CRIHB CTEC Advisory Council, which comprises community and health professional representatives from universities and Tribal Health Programs (THPs) in California.

The TBRFS builds on the work of the CDC BRFSS to obtain statewide data on health risk behaviors and protective factors of California AIAN. It is one of the most extensive state-based tools that focuses on the AIAN population. Health risk behaviors and protective factors include:

- Environmental health
- Health care access and routine preventative services
- Substance use specific to alcohol, commercial tobacco, and illicit drug use
- Dietary behaviors and physical exercise
- Chronic health conditions
- Cultural connection and spiritual health
- Mental health and well-being
- Adverse Childhood Experiences (ACE)

Brief executive summaries are available throughout the report for each health topic area (e.g., substance use, mental health, chronic health conditions), highlighting key findings. Survey results are displayed in charts or summary tables.

Findings from the TBRFS can be used by Tribes, Tribal and Urban Indian Health Programs (UIHPs), and other Tribal organizations for advocacy or policy-making purposes. Future iterations of the TBRFS will allow for monitoring trends over time and identifying strengths and areas of opportunity.

METHODS

The TBRFS included most of the CDC BRFSS modules. Additional questions were added to the survey to incorporate cultural connectedness. Angela Snowshoe's Cultural Connectedness Scale was used for the purpose of the survey.²

To ensure statewide representation, California was divided into seven regions. These include: North Coast and Cascades, San Francisco Bay Area, Delta and Gold Country, Central Coast, Central Valley, Greater Los Angeles, and the Inland Desert (Figure 1). The survey tool was divided into several categories which included physical, emotional, mental, and spiritual health. The sample size was calculated using the United States Census.

From June 2018 to January 2019, the CRIHB CTEC staff administered the TBRFS at 41 rural and urban events (cultural gatherings, health fairs, and Tribal and UIHPs). To be eligible, respondents had to be at least 18 years of age, identify as AIAN, reside in California, give consent, and not have taken the survey before. Respondents were given the option of taking the survey via tablet, weblink, or paper version. Upon completion, respondents were given the option to receive an incentive of a \$25 gift card for completing the TBRFS.

Survey questionnaires were built into Qualtrics, a secure online software platform. Upon completion, all paper-based surveys were entered into Qualtrics. The data were then imported to Microsoft Excel and SAS v9.4 for analysis. The TBRFS report utilized univariate and bivariate descriptive statistics to display the data. The number of respondents who skipped or did not answer a question is shown for each question. For example, if 60 respondents skipped a question in the survey, the report says "missing = 60." Skipped responses are not included in the graph calculations.



RESPONDENTS BY COUNTY

Figure 1

List of regions where survey respondents completed the TBRFS (n =2,149)



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Demographics



AIAN POPULATION IN CALIFORNIA

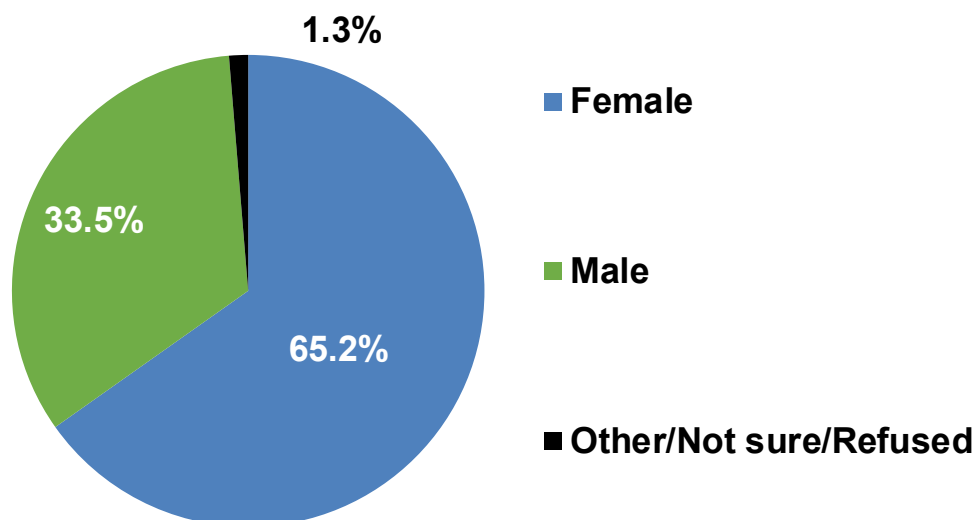
According to the 2010 Census data, California has the highest percentage of AIANs than any other state (14%). There are currently 109 federally recognized Tribes and several non-federally recognized Tribes in California.³ Currently, there are over 100 separate reservations and individual allotments throughout the state.³ In addition to identifying as AIAN, many identify with other races.⁴

The 2010 Census Data also showed that less than thirty percent of AIANs had a high school diploma, and only nine percent had a bachelor's degree. Compared to the national data, AIAN families live below the 200% poverty level compared to Whites.¹ Race for AIAN population can be classified by self-identification, Tribal enrollment, Indian descent, and many other factors.⁵ For the purposes of this report, all AIANs are self-identified.



GENDER

Figure 2

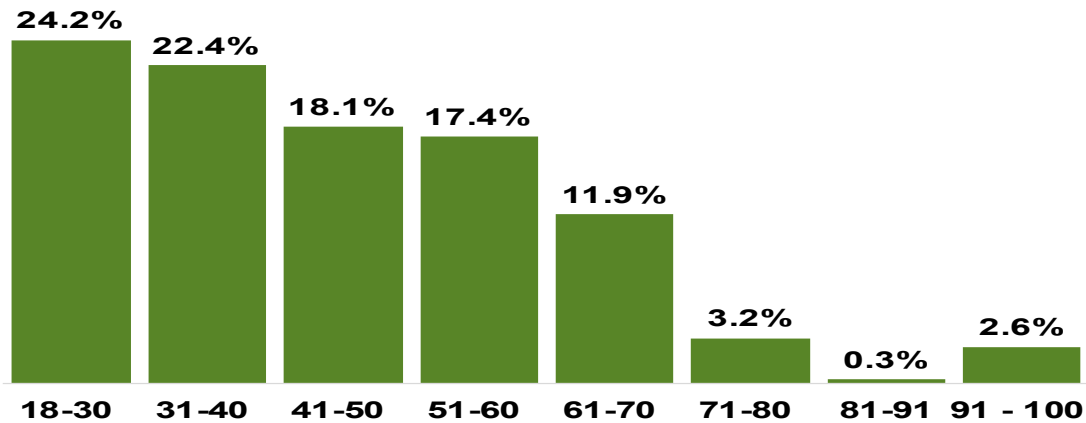


Of the 2,202 respondents, 65.2% were female and 33.5% were male (missing = 7).

AGE (YEARS)

Figure 3

Age-group of respondents

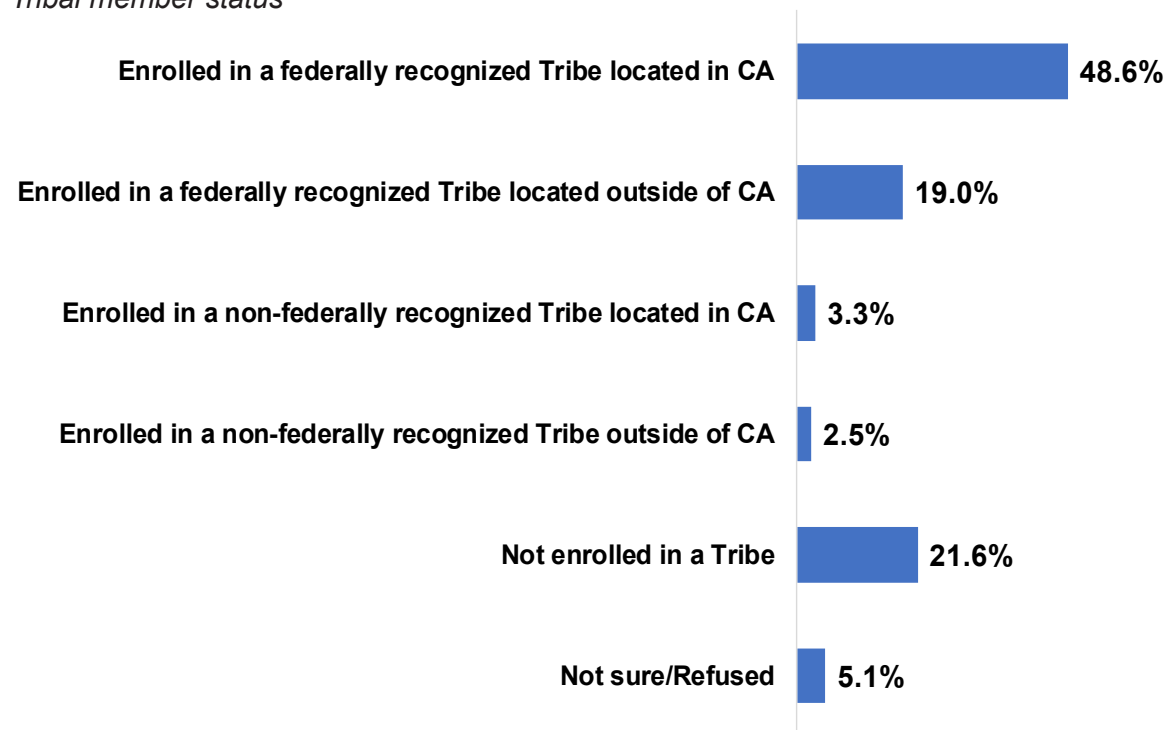


Of the 2,209 respondents, 24.2% were between the ages of 18 and 30, followed by those who were between 31 and 40 (22.4%), then by those who were between 41 and 50 (18.1%). The average age was 63 and the median age was 42.

ENROLLED MEMBER OF A TRIBE

Figure 4

Tribal member status

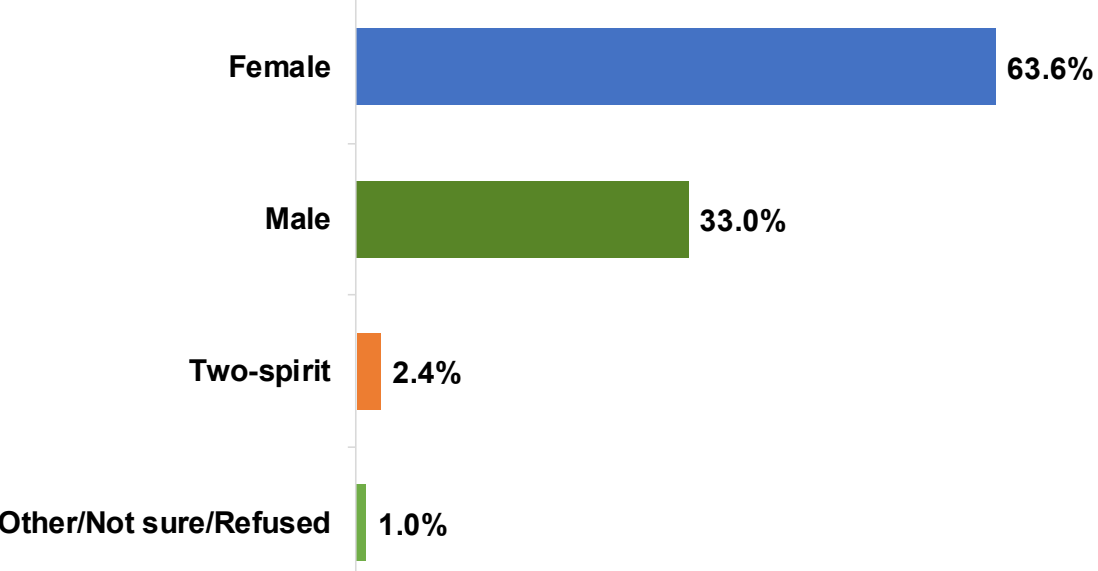


Of the 2,209 respondents, 48.6% were enrolled in a federally recognized Tribe in California. About three-fourths of the respondents (73.3%) were enrolled in any Tribe (whether federally recognized or not).

GENDER IDENTIFICATION

Figure 5

Gender identification

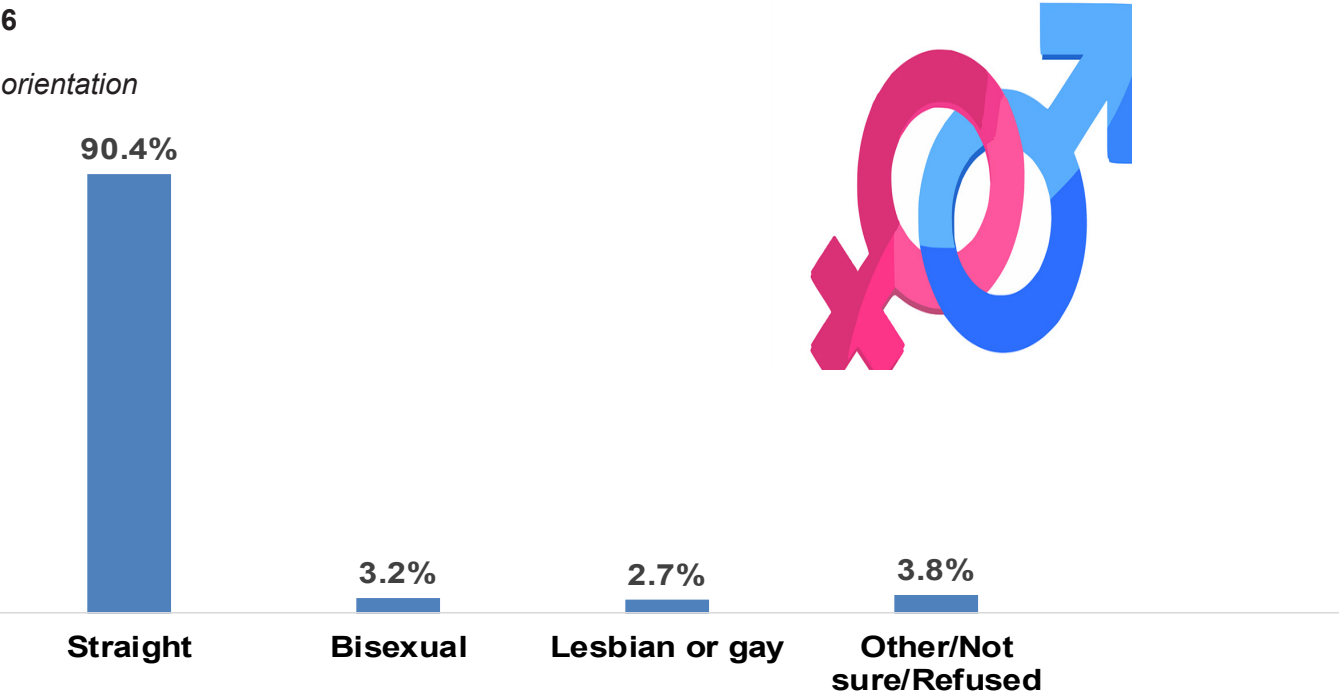


Of the 2,200 respondents who reported their gender identity, 63.6% were female, 33.0% male, and 2.4% Two-spirit (missing = 9).

SEXUAL ORIENTATION

Figure 6

Sexual orientation

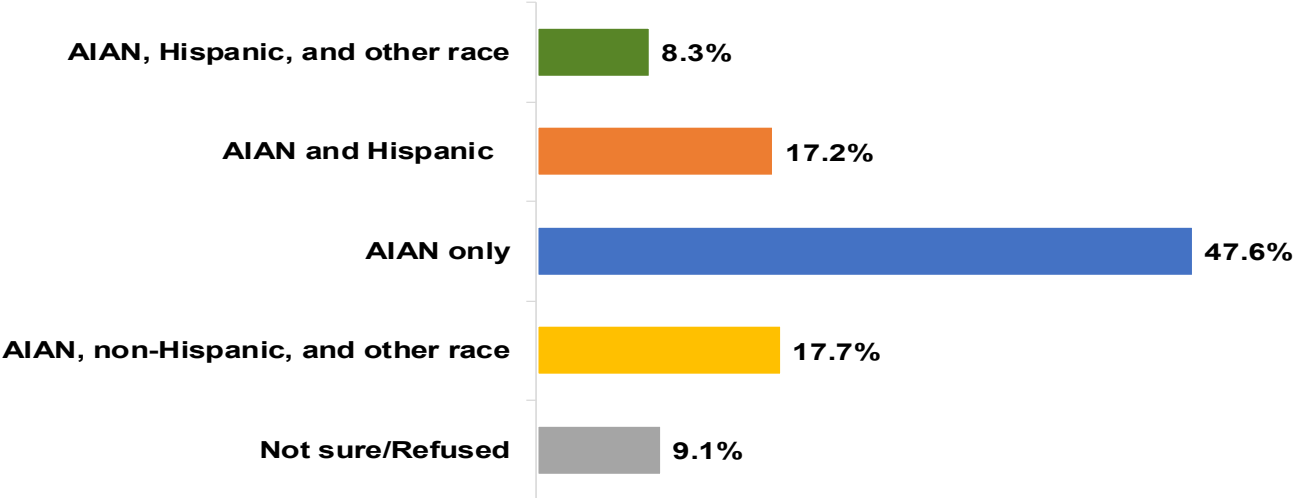


Of the 2,209 respondents, 90.4% identified as straight, 3.2% identified as bisexual, and 2.7% identified as lesbian or gay.

RACIAL IDENTIFICATION

Figure 7

Identified as AIAN/non-Hispanic or in combination



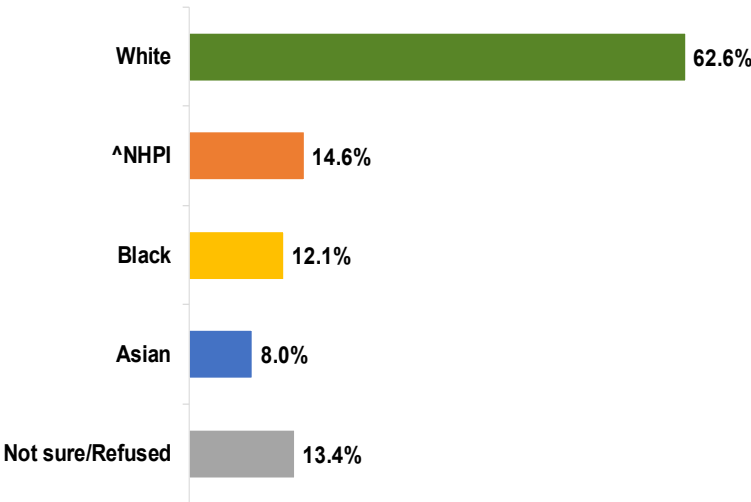
Of the 2,209 total respondents, 47.6% reported as being AIAN only and 17.2% reported they were AIAN and Hispanic.



RACE CATEGORIES

Figure 8

Race in addition to AIAN



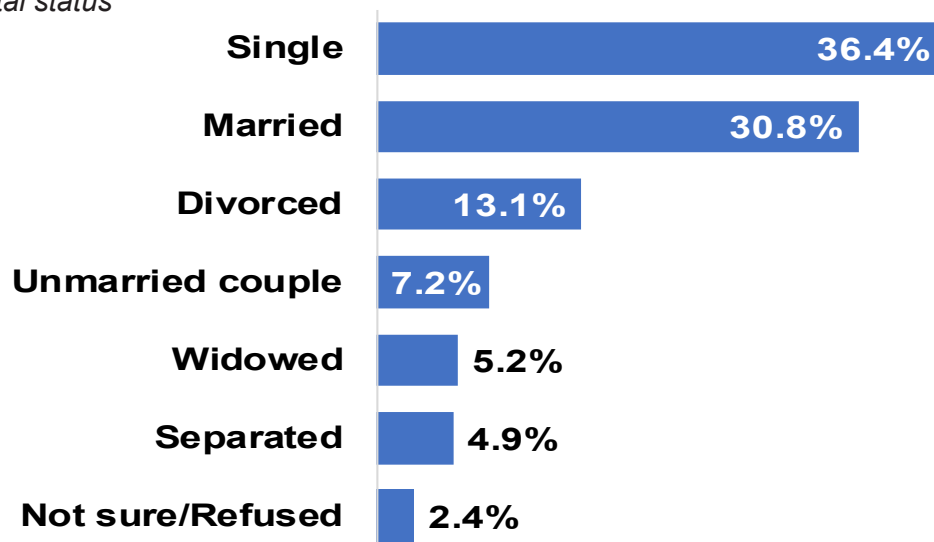
Of the 597 respondents who answered if they identified with another race in addition to being AIAN, 62.6% said White, followed by those who said they had other races in their background (34.7%). Multiple choices were allowed, therefore the total will not equal 100%.

Note: ^Native Hawaiian/Pacific Islander

MARITAL STATUS

Figure 9

Marital status

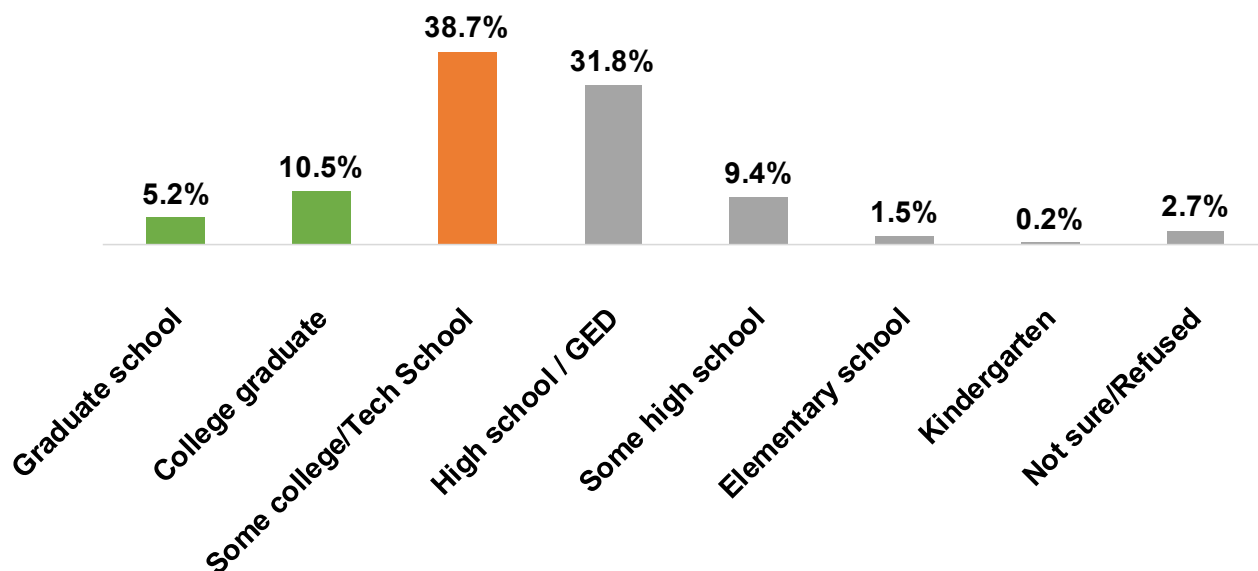


Of the 2,209 respondents, 36.4% answered they were single, followed by those (30.8%) who were married, and then by those (13.1%) who were divorced.

EDUCATION

Figure 10

Highest level of education attained

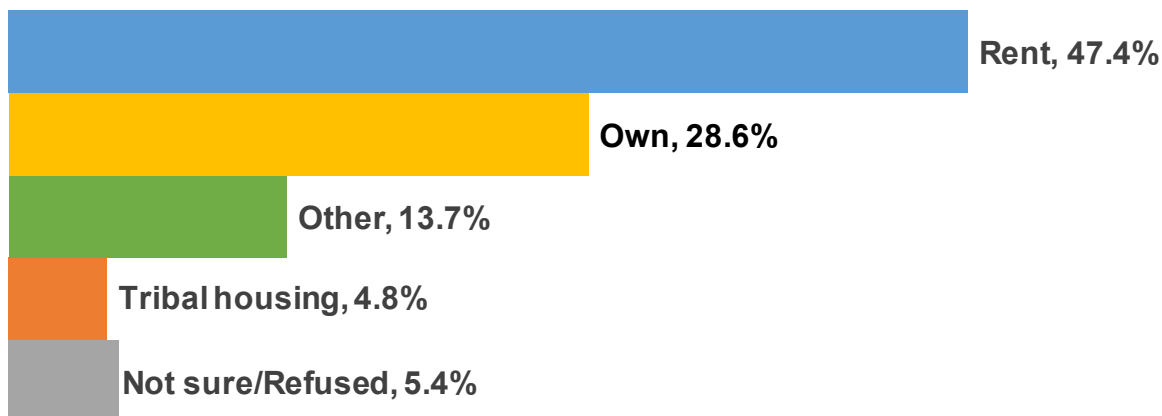


Of the 2,209 respondents, 38.7% said they had attended some college or Technical School, closely followed by those that had graduated high school or received their GED (31.8%).

RESIDENTIAL STATUS

Figure 11

Rented, owned, or lived in Tribal housing

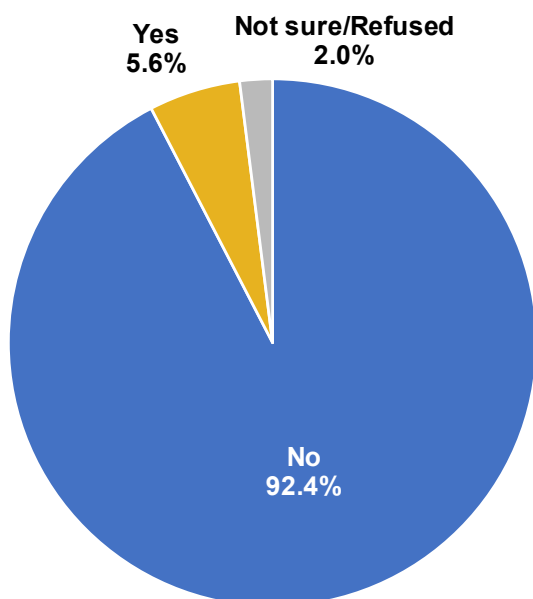


Of the 2,209 respondents, 47.4% said they were renting, while nearly 28.6% answered they owned a home. Only 4.8% were in Tribal housing.

MILITARY SERVICE

Figure 12

Served in the United States Armed Forces



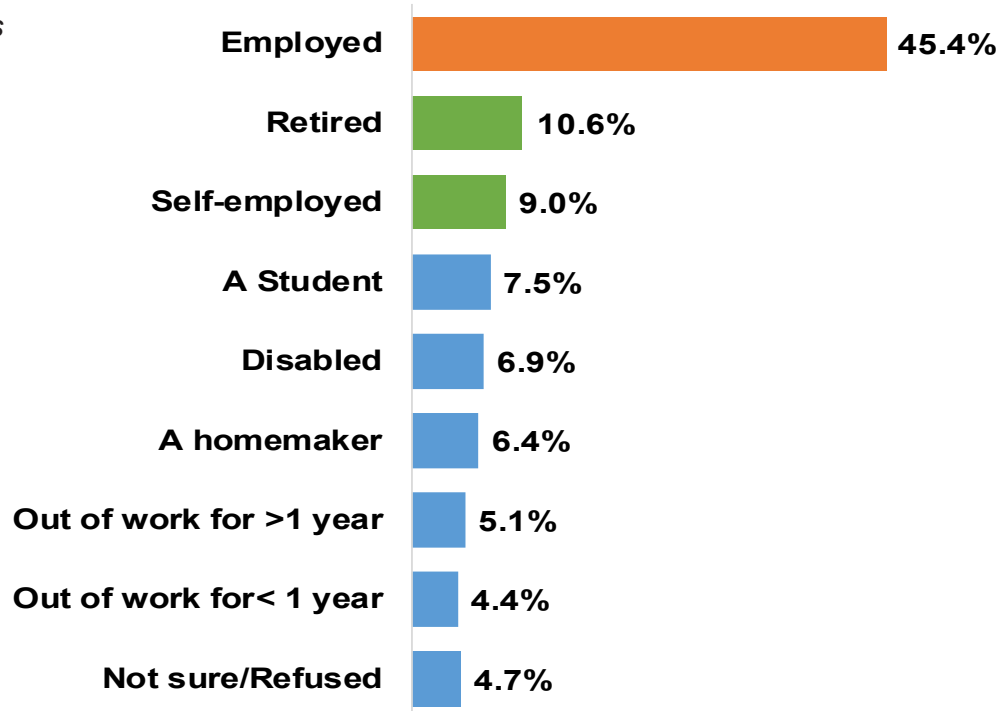
Of the 2,209 respondents, 5.6% answered they had served in the military.



EMPLOYMENT

Figure 13

Employment status

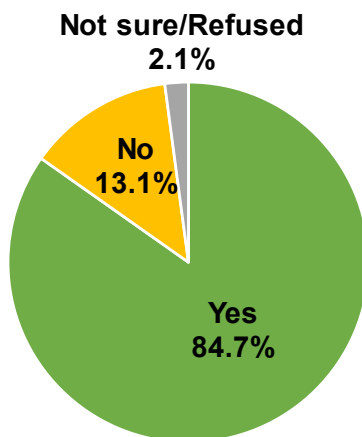


Of the 2,209 respondents, 45.4% were employed for wages, followed by those (10.6%) who were retired, then by those (9.0%) who were self-employed.

INTERNET USAGE

Figure 14

Used the Internet in the past 30 days

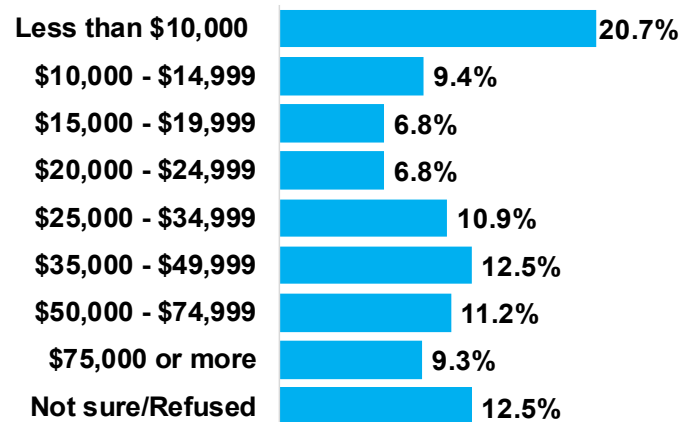


Of the 2,209 respondents (84.7%) said they had used the Internet in the past 30 days.

HOUSEHOLD INCOME

Figure 15

Annual household income



Of the 2,209 respondents, 20.7% said their annual income was less than \$10,000, followed by those (12.5%) that reported their income was between \$35,000-49,999.

Physical Health Behaviors



HEALTH STATUS

Health status takes into account behavioral, social, and, environmental factors. Self-perceptions of health status can be both a predictor and an indicator of health outcomes.⁶ These factors may impact an individual's health-related quality of life and can also serve as an indicator for the utilization of health care systems, as people generally seek health care only when feeling unhealthy.

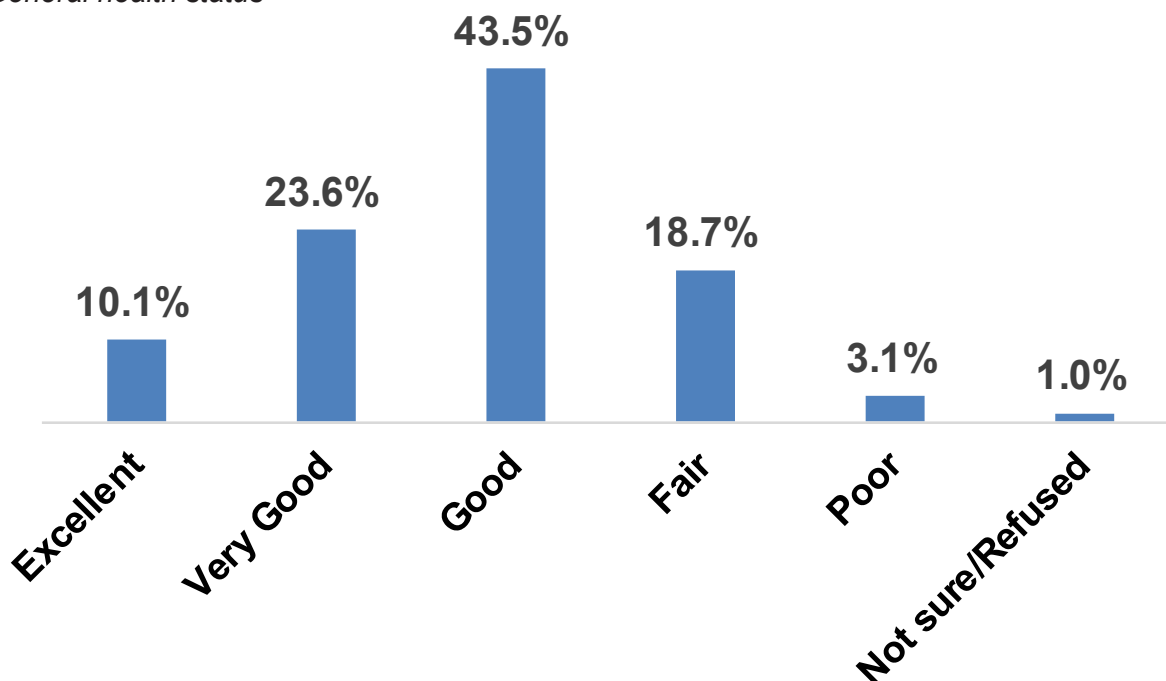
Studies showed that respondents' answers to the physical health questions were consistent with reported medical care utilization. Additionally, levels of stress and mental distress are predictive of disease and health care utilization. Unhealthy physical and mental health days can limit usual activities and hinder healthy behaviors.⁷



GENERAL HEALTH

Figure 16

General health status

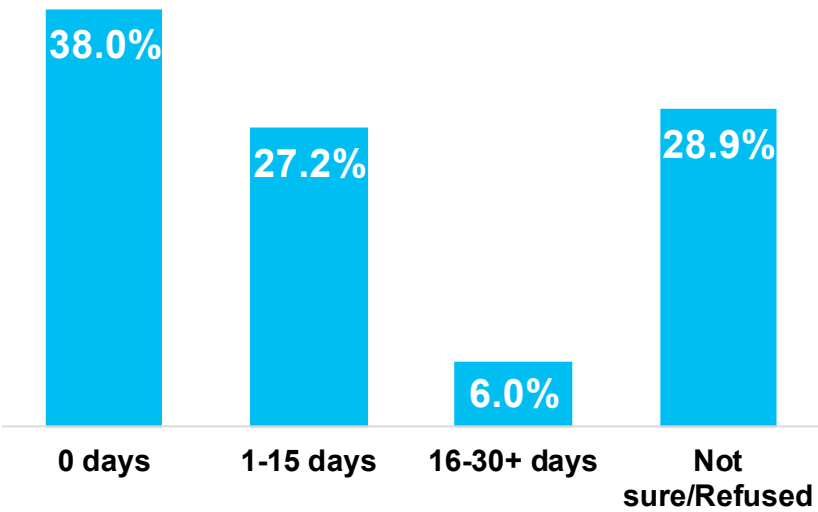


Of the 2,209 respondents, only 3.1% said their general health was poor.

UNABLE TO DO USUAL ACTIVITIES

Figure 17

Number of days respondents were unable to do usual activities due to poor physical or mental health, such as self-care, work, or recreation during the past 30 days

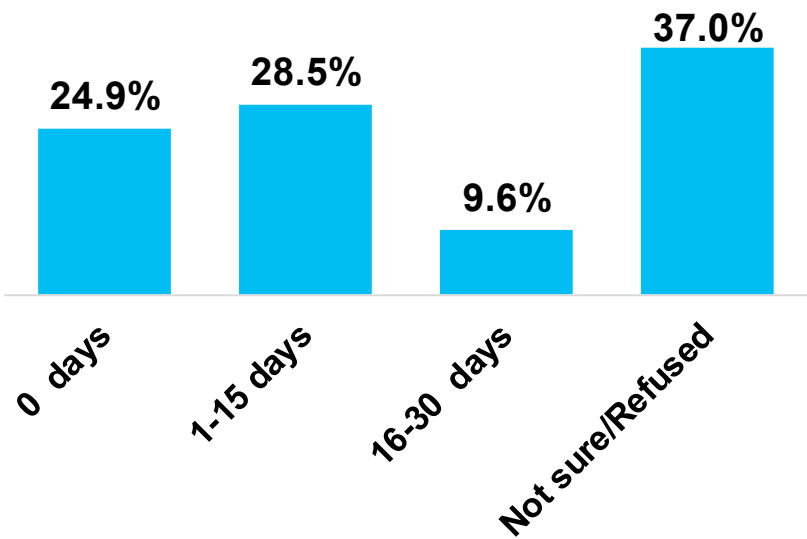


Of the 2,209 respondents, 27.2% reported that poor physical health kept them from doing their usual activities between one and 15 days.

DAYS OF POOR PHYSICAL HEALTH

Figure 18

Number of days respondents had poor physical health during the past 30 days



Of the 2,209 respondents, 28.5% said they had poor physical health between one and 15 days and almost 10% had poor health for more than half the month.

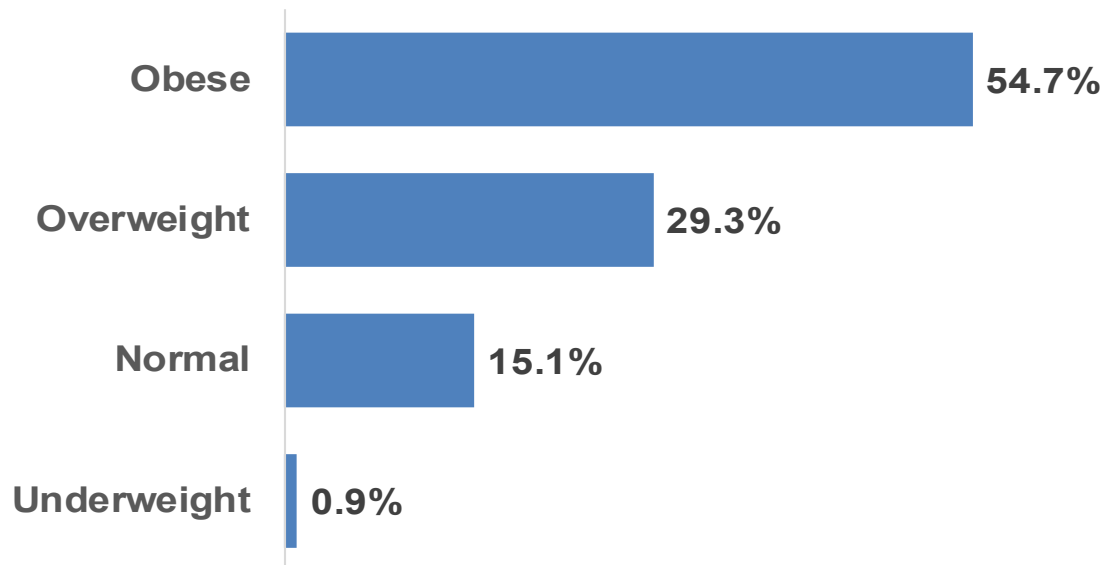




BODY MASS INDEX

Figure 19

Body Mass Index (BMI)

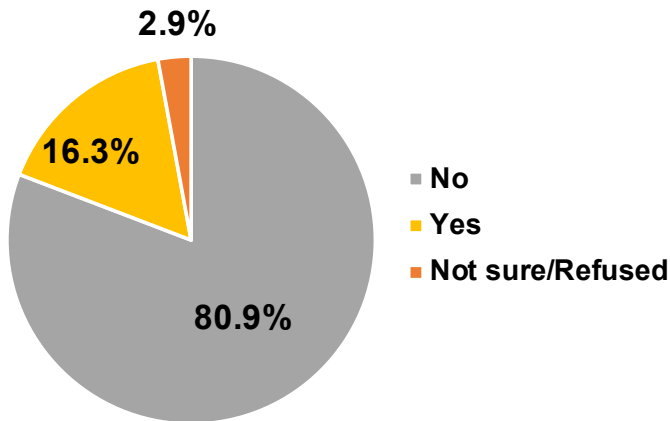


Of the 2,209 respondents, 54.7% were considered obese based on BMI.

MOBILITY

Figure 20

Had difficulty walking or climbing stairs

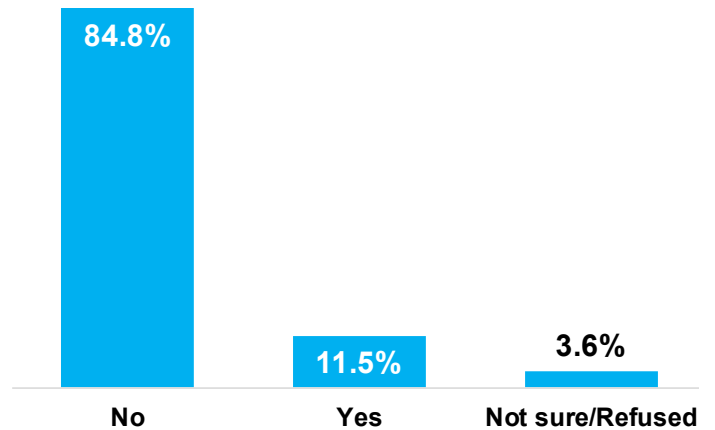


Of the 2,209 respondents, 16.3% said they had difficulty walking or climbing stairs.

RUNNING ERRANDS

Figure 21

Had difficulty running errands

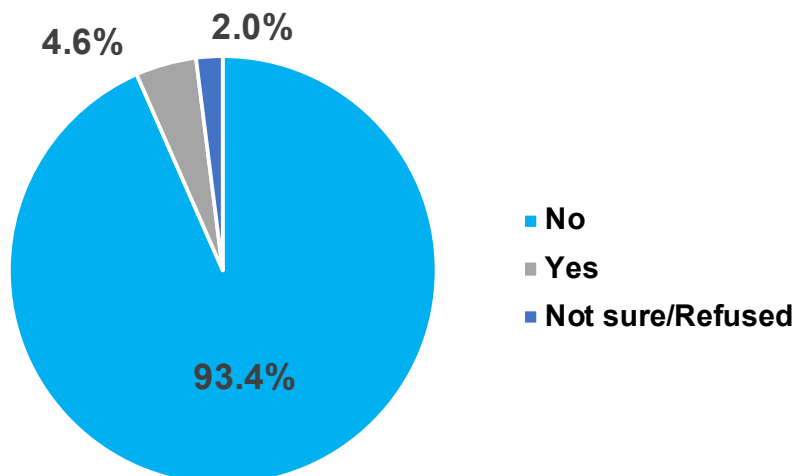


Of the 2,209 respondents, 11.5% said they had difficulty doing errands.

DIFFICULTY BATHING OR DRESSING

Figure 22

Had difficulty bathing or dressing



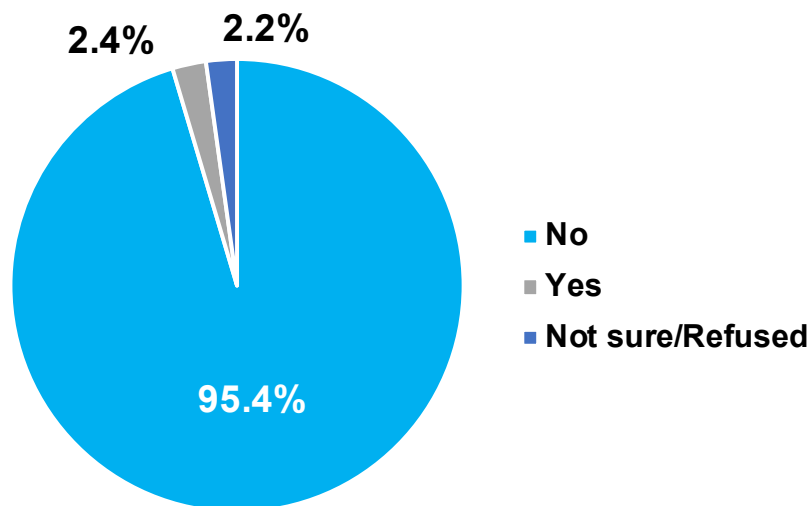
Of the 2,209 respondents, less than five percent had difficulty bathing or dressing.



PREGNANCY

Figure 23

Were pregnant at the time of the survey

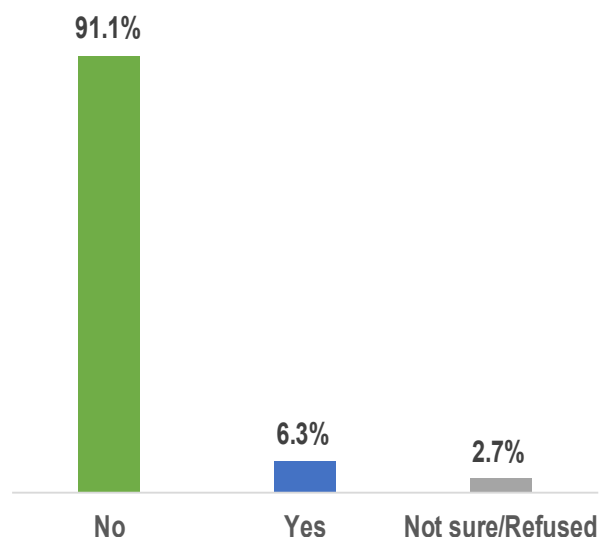


Of the 1,443 female respondents, 2.4% answered they were pregnant at the time of the survey.

HEARING ABILITY

Figure 24

Were deaf or had serious difficulty hearing

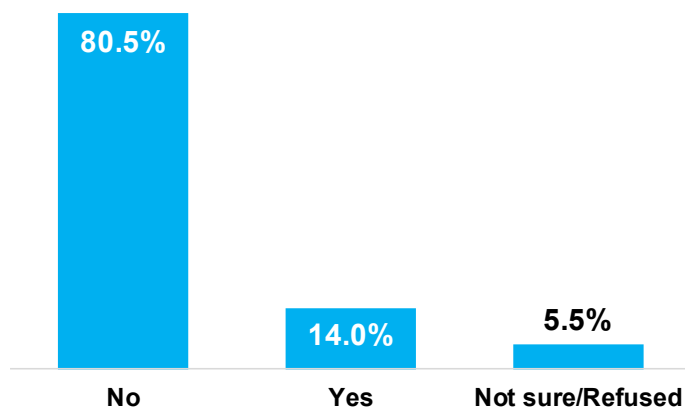


Of the 2,209 respondents, 6.3% reported that they were deaf or had serious difficulty hearing.

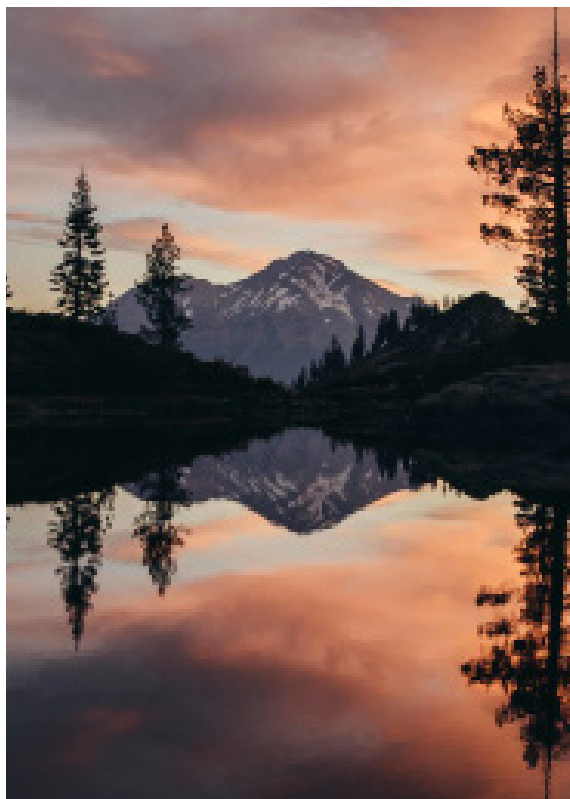
DECISION MAKING

Figure 25

Had difficulty making decisions due to a physical, mental, or emotional condition



Of the 451 respondents 14.0% said they did have difficulty making a decision due to a physical, mental, or emotional condition (missing = 1,758).



HEALTH CARE ACCESS

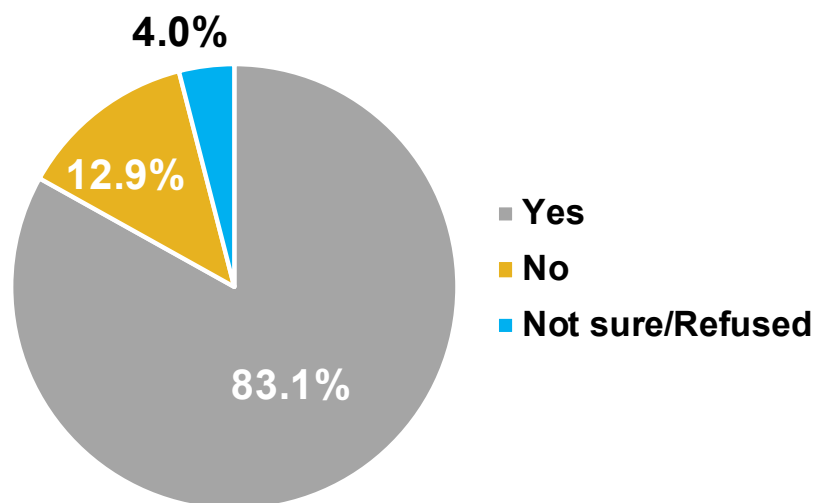
Access to quality and comprehensive health care can reduce unnecessary disability and premature death, improve quality of life, and help achieve health equity. From prevention to timely treatment, access and utilization of health care are imperative for promoting and maintaining health. In the United States, access to care varies significantly by race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residential location. These limitations that hinder equitable access can impact individuals' physical, social, and mental health status and result in a decreased quality of life. While access is just a piece of what helps maintain and promote good health, it is important to examine and resolve the barriers to improving health outcomes.

Utilizing care can be impacted by the availability of quality services, insurance coverage, and timeliness of care. Barriers such as high costs, excessive wait times, lack of transportation, lack of culturally competent care, and difficulty scheduling are all deterrents to receiving care and can impact an individual's health and entire communities. The TBRFS explored these barriers to access while asking about health services, insurance coverage, routine check-ups, and health care satisfaction.⁸

HEALTH CARE COVERAGE

Figure 26

Health coverage insurance status



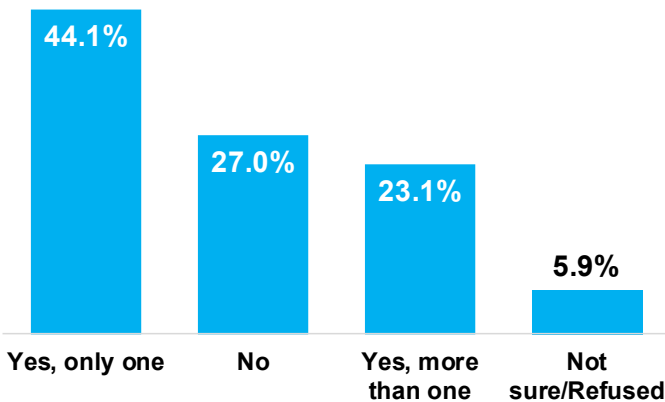
Of the 2,209 respondents, 12.9% reported that they did not have health coverage.



NUMBER OF HEALTH CARE PROVIDERS

Figure 27

Had one or more healthcare providers

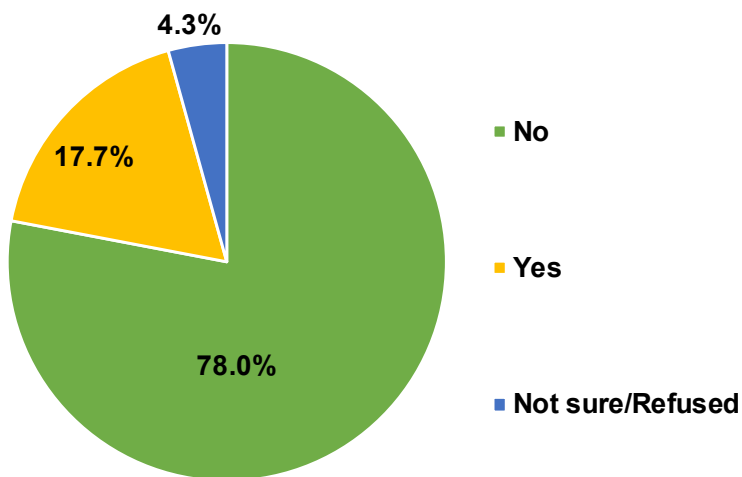


Of the 2,209 respondents, 44.1% had only one person they thought of as their health provider, followed by 23.1% who had more than one person they considered a health provider.

VISITING A DOCTOR DUE TO COST

Figure 28

Had difficulty visiting a doctor due to cost

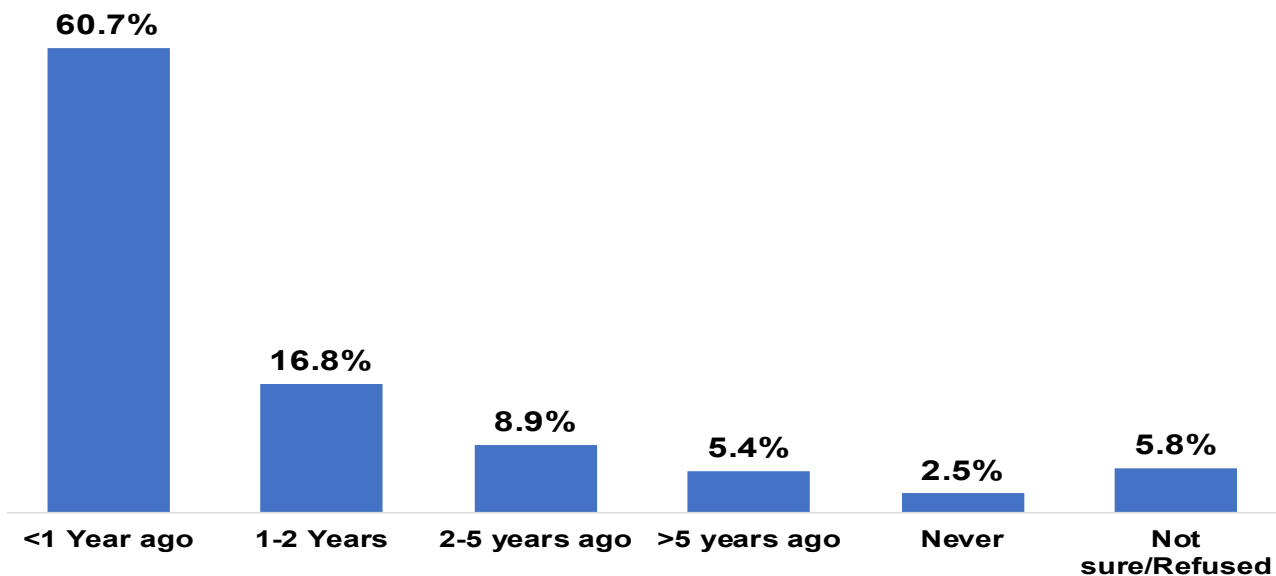


Of the 2,209 respondents, 17.7% had difficulty visiting a doctor due to cost.

ROUTINE CHECK-UP

Figure 29

Were last seen by a doctor for a routine check-up

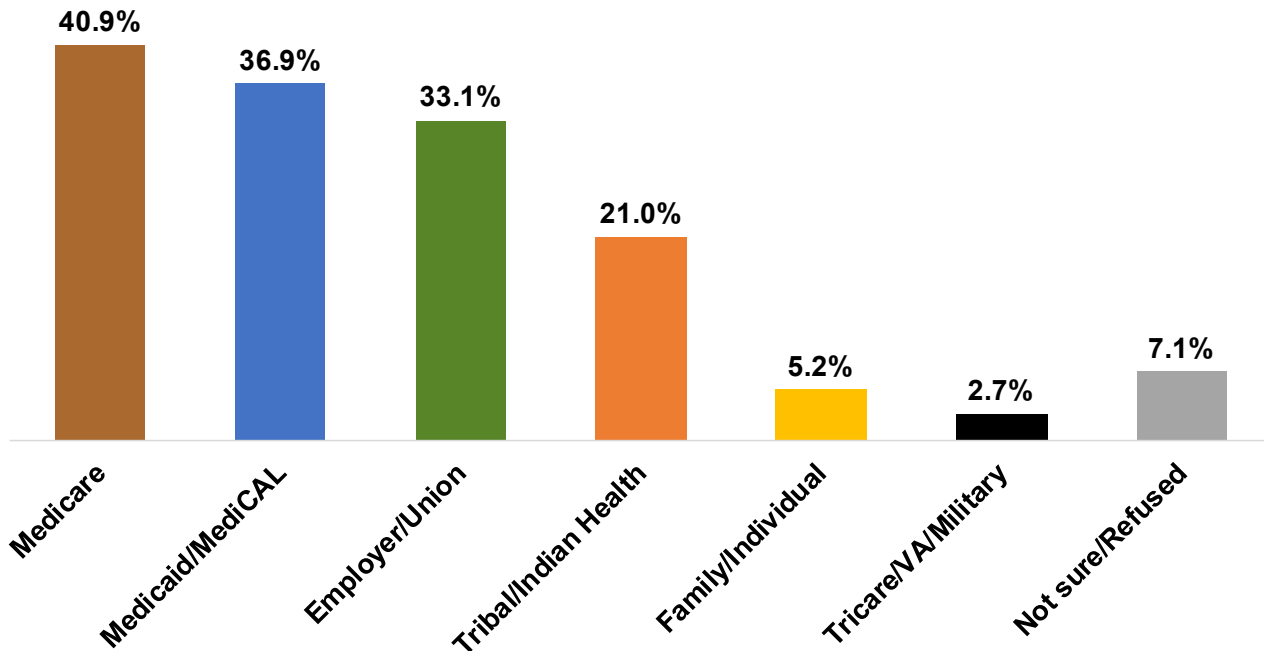


Of the 2,209 respondents, almost one-third had not seen a doctor for more than one year for a routine check-up.

SOURCE OF HEALTH COVERAGE

Figure 30

Source of Health Care Coverage



Among the 1,835 respondents that reported having any kind of health insurance, just under 60% had government provided insurance (Medicare and/or Medi-Cal). Note: Respondents were allowed to choose multiple responses.

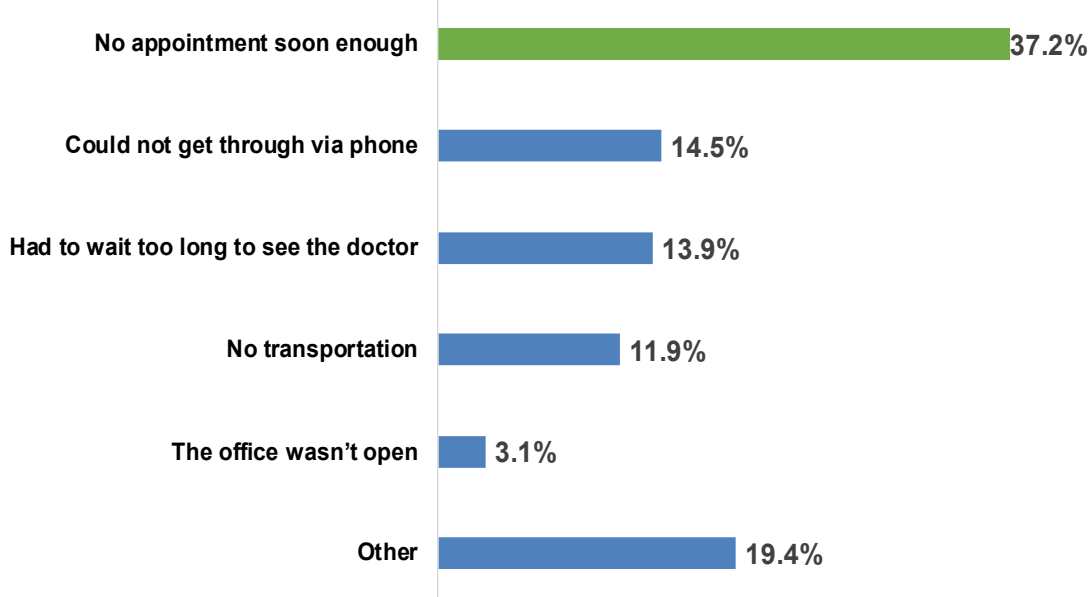


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DELAY IN MEDICAL CARE

Figure 31

Had delays in getting medical care for reasons other than cost

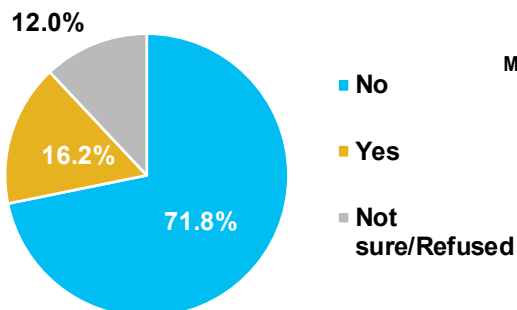


Of the 2,209 respondents, 30.9% reported they had delays in getting medical care for reasons other than cost. Of the 682 who reported they had delays, 37.2% said they couldn't get an appointment soon enough. Other reasons for delays in getting medical appointments include not getting enough sick time, tiredness, lack of childcare, fear of medical care, or schedule conflicts.

NO HEALTH INSURANCE IN THE PAST 12 MONTHS

Figure 32

Did not have insurance in the past 12 months

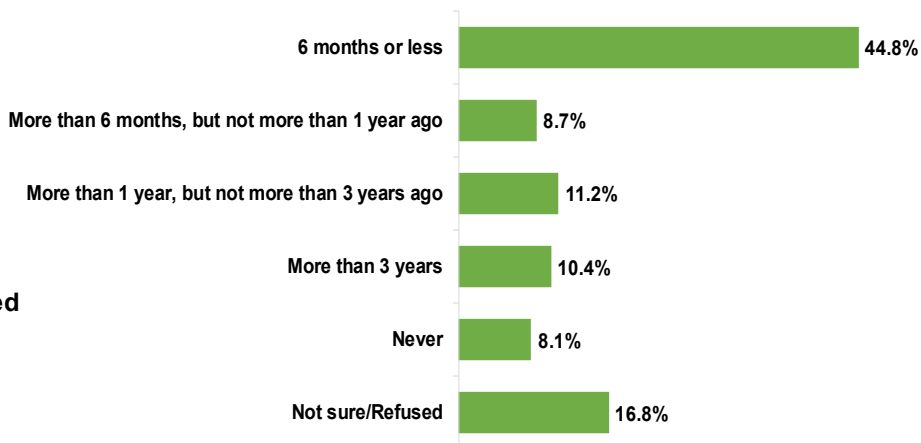


Of the 2,209 respondents, 16.2% reported that they did not have any health insurance in the past 12 months.

LAST HAD HEALTH COVERAGE

Figure 33

Period of time since respondent had health care coverage

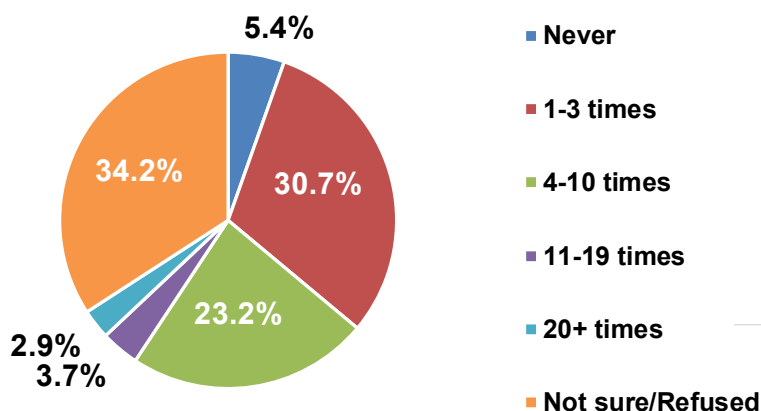


Of the 357 respondents, who reported not having health insurance, 29.7% said they had been without it for more than one year.

BEEN TO THE DOCTOR IN THE PAST 12 MONTHS

Figure 34

Had been to the doctor in the past 12 months

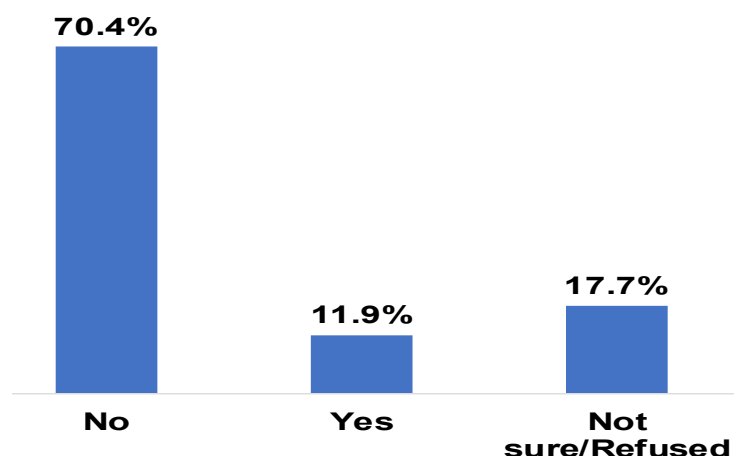


Of the 2,209 respondents, about five percent reported that they had not been to the doctor in the past 12 months.

NONCOMPLIANCE AND MEDICATIONS

Figure 35

Had not taken medication because of cost

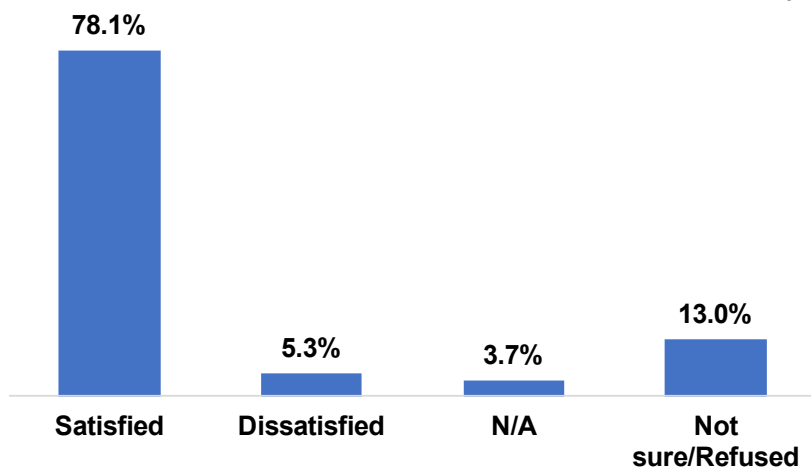


Of the 1,976 respondents who prescribed medication, not including over-the-counter medications, about ten percent reported that they had not taken medication due to cost.

HEALTH CARE AND SATISFACTION

Figure 36

Were satisfied with the health care they received

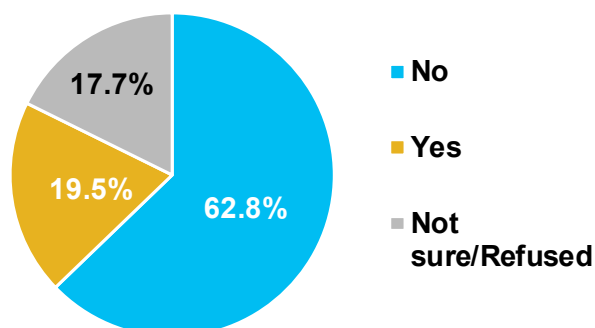


Of the 2,209 respondents, about five percent reported that they were not satisfied with the health care they received.

HEALTH CARE BILLS

Figure 37

Had any health care bills that are being paid off over time



Of the 2,209 respondents, about twenty percent reported they had health care bills that were being paid off over time.

SEXUAL BEHAVIORS

Sexual behaviors that often affect the AIAN population include risky behaviors. These can include noncompliance with safe sex practices, multiple partners, and drugs/drinking.

Early indications for risky sexual behavior most often occurs during adolescence and may progress into adulthood. Although lower than other races, AIAN are also at heightened risk for HIV and Sexually Transmitted Infections (STI).⁹

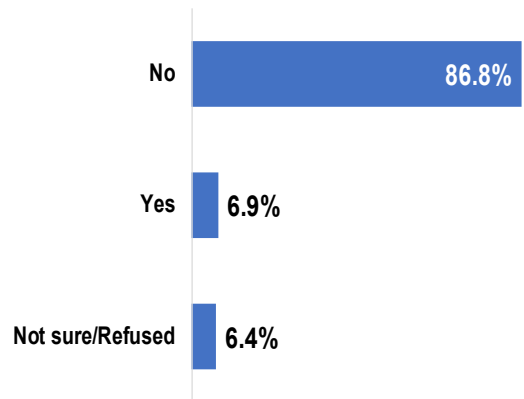
Emerging adulthood (18-29 years old) is an essential time in life. This period is often a time of exploration in love, sexual encounters, identity, and world views. Sexual identity and behavior should be carefully self-monitored.¹⁰



ANAL SEX AND CONDOM USE

Figure 38

Had anal sex without a condom in the past year

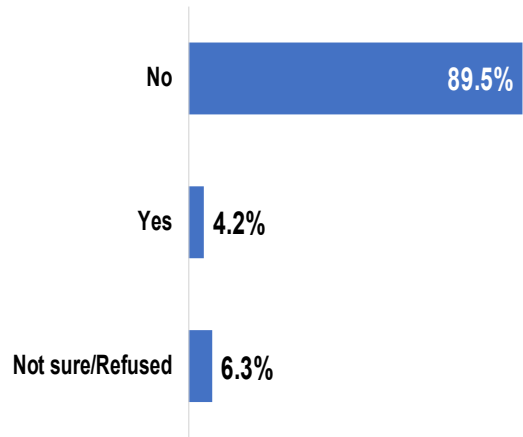


Of the 2,209 respondents, less than ten percent reported having anal sex without a condom.

MULTIPLE SEX PARTNERS

Figure 39

Had four or more sex partners in the past year

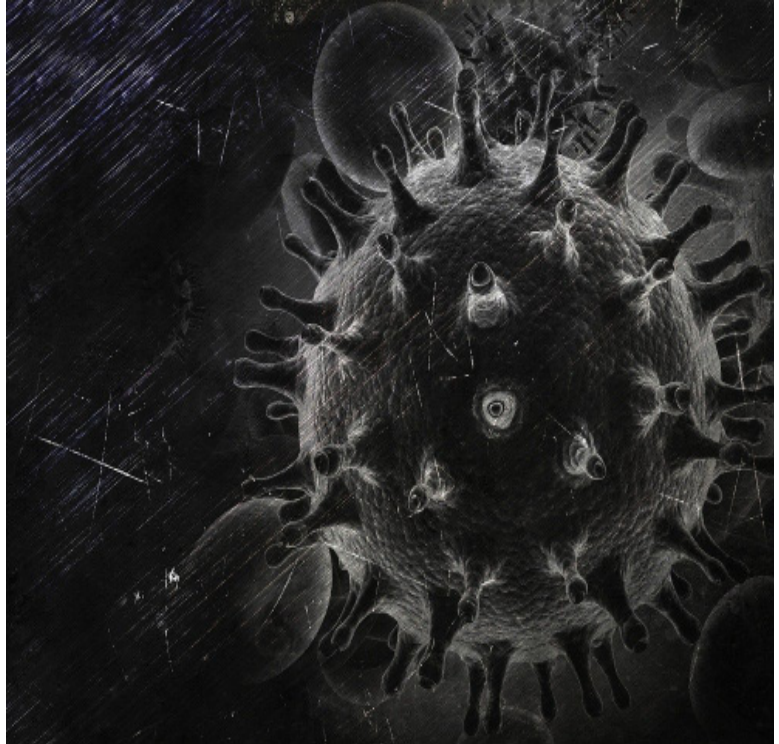


Of the 2,209 respondents, less than five percent said they had four or more partners in the past year.

HIV

HIV is a viral infection that attacks the immune system and causes Acquired Immunodeficiency Syndrome. While there is no cure for HIV, proper medical care can lead to long, healthy lives.

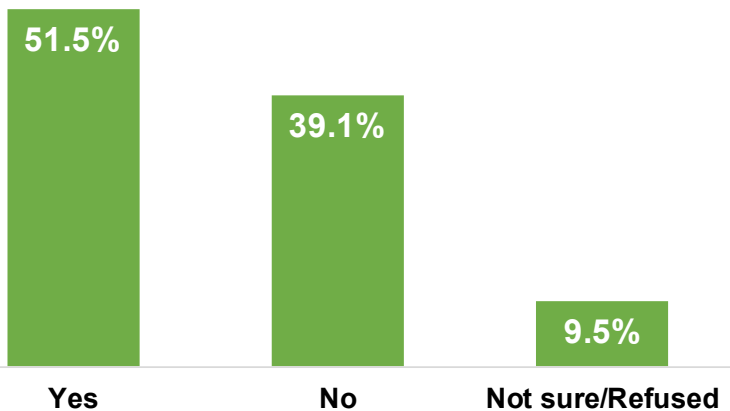
The CDC recommends that everyone between the ages 13 and 64 should be tested for HIV as 40% of new HIV infections are transmitted by people who do not know they have the virus.⁹ Advances in testing now make it possible to self-test for HIV entirely at home or in a private location. The rapid self-assessment kits are available at a pharmacy or online.¹¹



HIV

Figure 40

Were tested for HIV

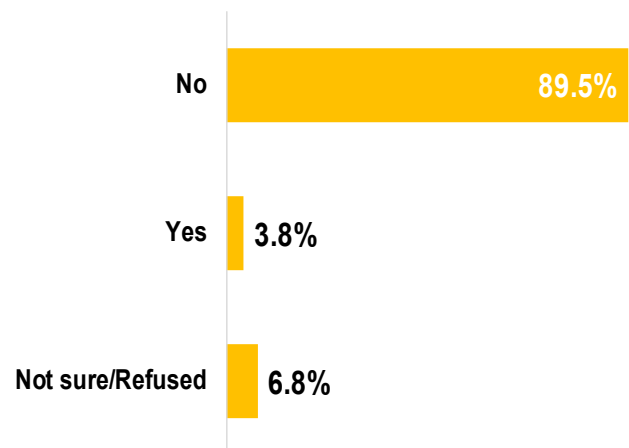


Of the 2,209 respondents, 51.5% answered they had ever been tested for HIV.

STD

Figure 41

Were treated for an STD in the past year



Of the 2,209 respondents, fewer than five percent said they had not been treated for an STD test in the past year.

HYPERTENSION

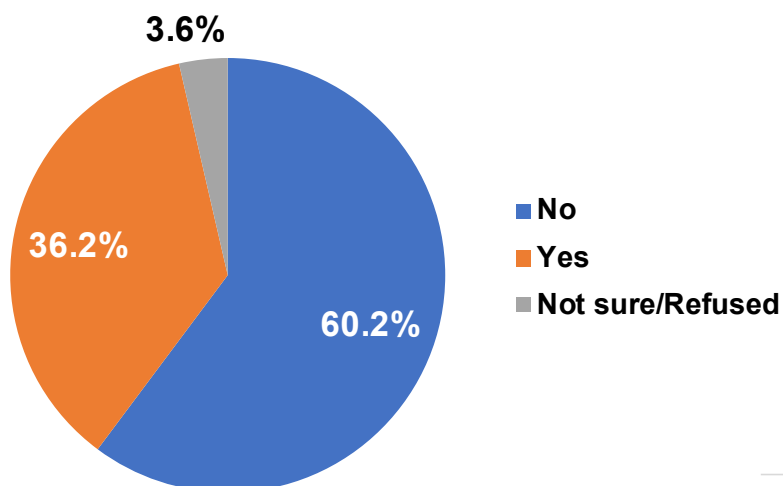
High blood pressure, also called hypertension, is blood pressure that is higher than normal. Blood pressure changes throughout the day based on an individual's activities. Having blood pressure measures consistently above normal may result in a diagnosis of high blood pressure (or hypertension). The higher your blood pressure levels, the more risk you have for other health problems, such as heart disease, heart attack, and stroke. High blood pressure usually has no warning signs or symptoms, and many people do not know they have it.¹²



BLOOD PRESSURE

Figure 42

Were told by a health professional that they had high blood pressure

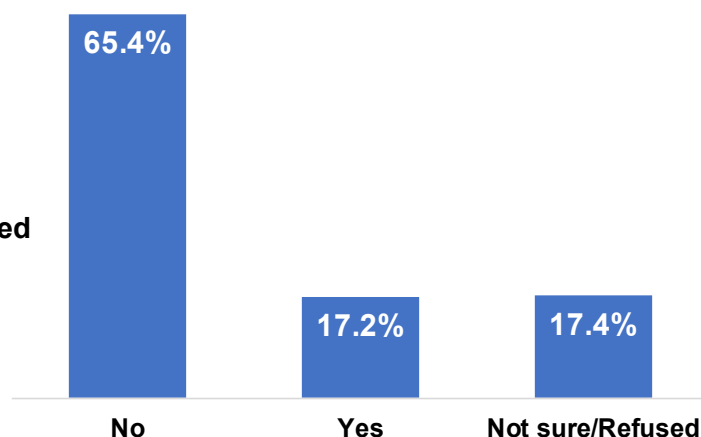


Of the 2,209 respondents, 36.2% reported they were told they had high blood pressure.

BLOOD PRESSURE WHILE PREGNANT

Figure 43

Were told by a health professional that they had high blood pressure only while pregnant

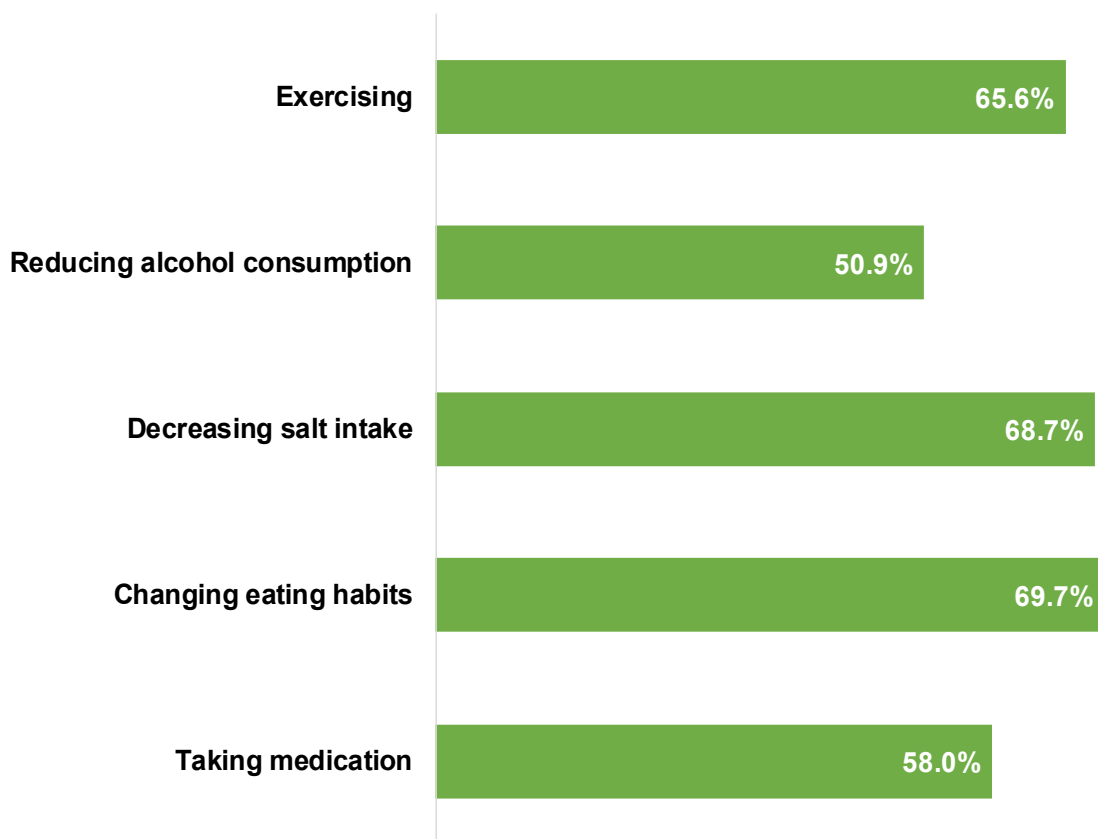


Of the 512 female respondents who were told they had high blood pressure, 17.2% were only when they were pregnant.

BLOOD PRESSURE MANAGEMENT ON THEIR OWN

Figure 44

Were decreasing blood pressure lowering salt intake, changing their eating habits, increasing exercise, reducing alcohol intake or taking medication on their own



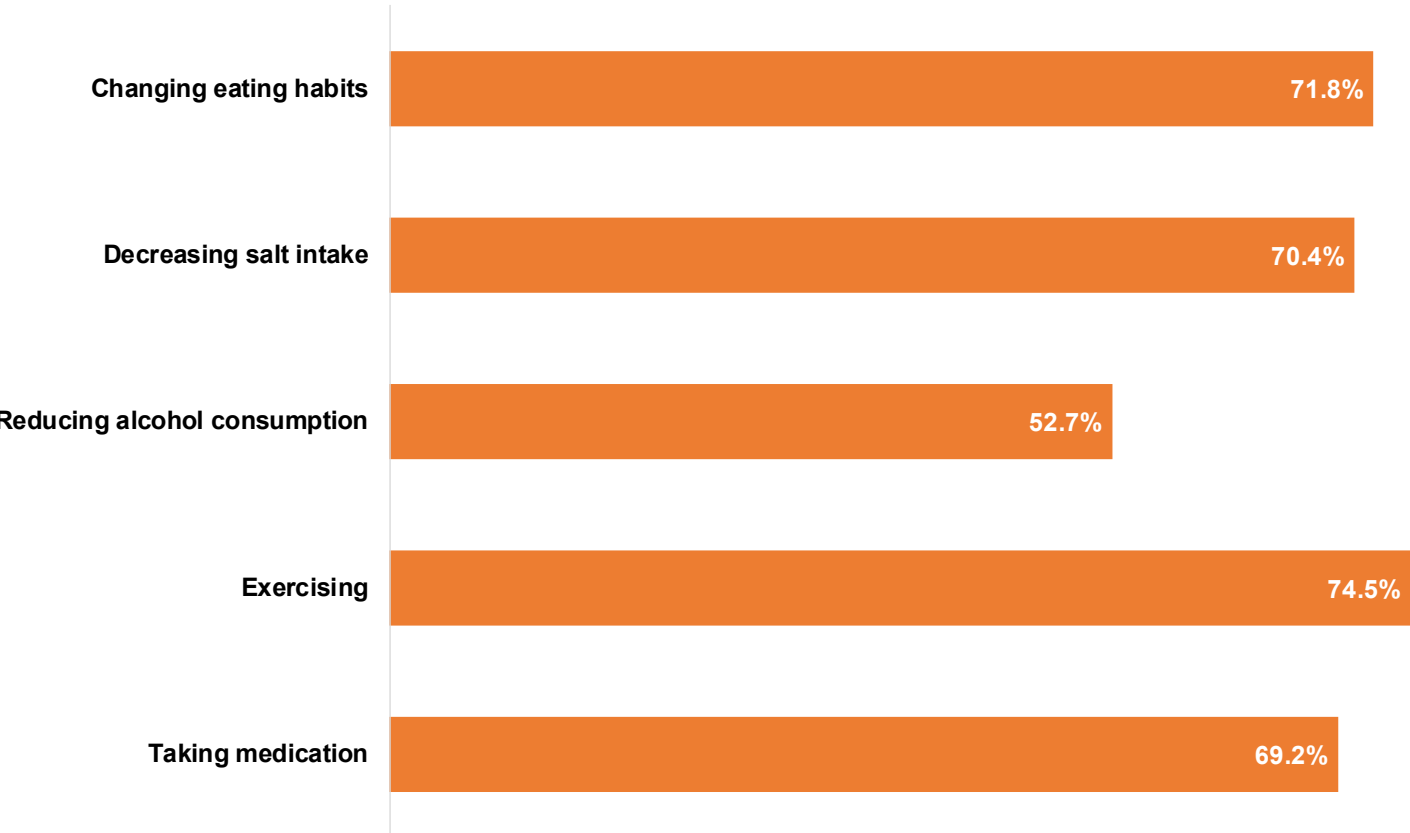
Of the 788 respondents who were diagnosed with high blood pressure by a health professional, more than half were changing their lifestyle habits on their own.



RECOMMENDED TO REDUCE BLOOD PRESSURE BY A DOCTOR

Figure 45

Measures recommended by a health professional to lower blood pressure



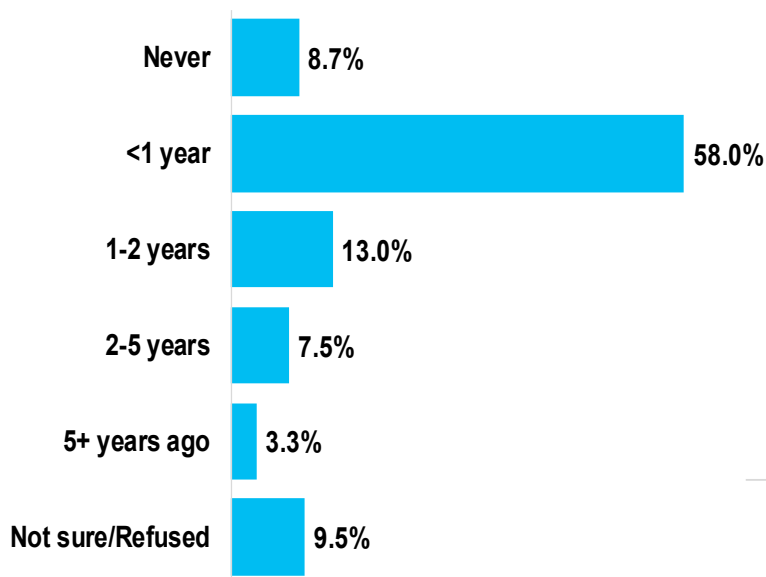
Of the 788 respondents, who were told they had high blood pressure by a health professional, more than half were given recommendations to change their lifestyle habits to reduce their high blood pressure.



CHOLESTEROL LEVEL STATUS

Figure 46

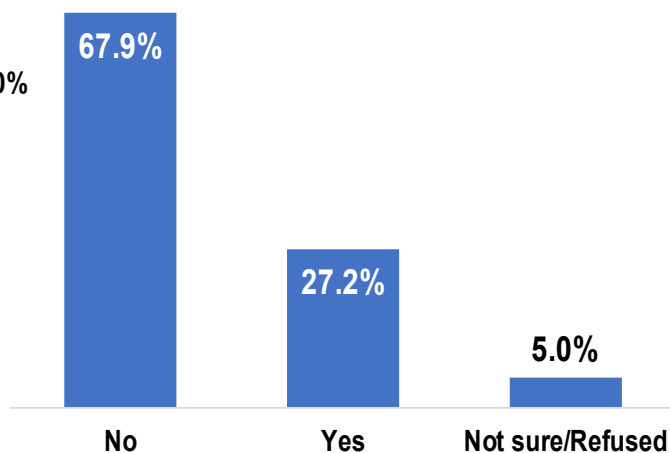
Were checked for blood cholesterol level by a health professional



Of the 2,209 respondents, 8.7% were never checked for their blood cholesterol levels.

Figure 47

Were told by a health professional they had high cholesterol

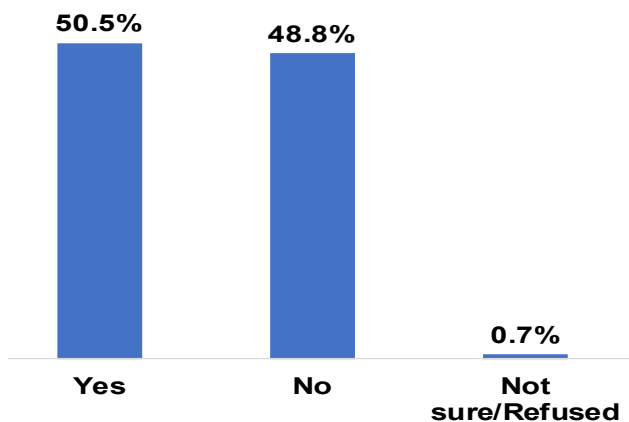


Of the 2,209 respondents, 27.2% were told they had high blood cholesterol.

CHOLESTEROL MEDICATION USAGE

Figure 48

Were taking medication to reduce their blood cholesterol



Among the 600 respondents, who were diagnosed with high cholesterol, about half were not taking medication for it.



CHRONIC HEALTH CONDITIONS

Chronic diseases are defined as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.¹¹ This includes heart disease, cancer, diabetes, chronic lung disease, Alzheimer's, chronic kidney disease, and stroke. According to the CDC, six in ten adults in the United States have a chronic disease, and four in ten have two or more. Lifestyle choices and health risk behaviors (e.g., smoking, poor nutrition, lack of physical activity, excessive alcohol) can significantly influence the likelihood of being diagnosed with a chronic health condition.

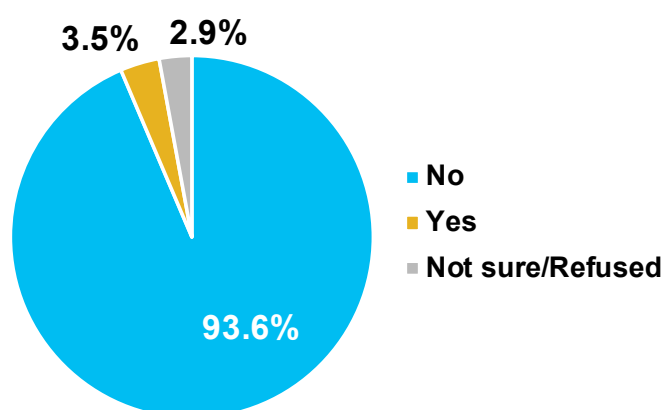
Chronic health conditions further influence physical and mental health, while taking a toll on the health care economic systems. CDC estimates that 90% of the nation's health care expenditures are for people with chronic and mental health conditions. Prevention and management of symptoms are the most cost-effective ways of reducing the burden of chronic health conditions at the individual and societal levels. Chronic pain is commonly associated with many chronic health conditions from arthritis to diabetes to autoimmune disorders. Often times this pain can cause frequent limitations in life or work activities (high-impact chronic pain). Pain management can help patients improve their quality of life associated with chronic pain.¹³



HEART ATTACK

Figure 49

Ever been told by a health professional that they had a heart attack or myocardial infarction

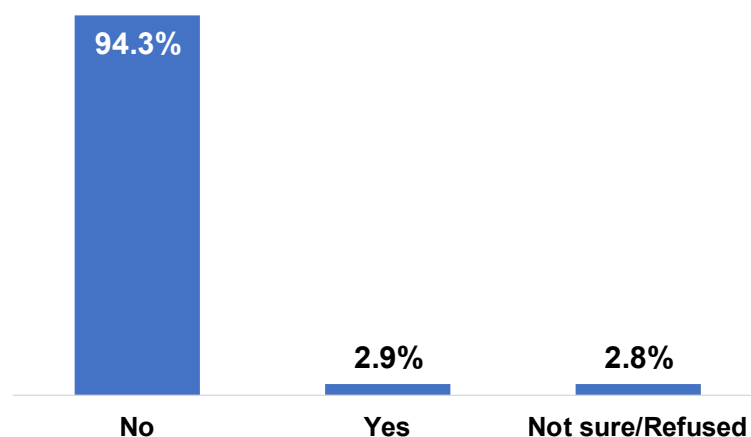


Of the 2,209 respondents, less than five percent were told they had a heart attack or myocardial infarction.

ANGINA OR CORONARY HEART DISEASE

Figure 50

Ever been told by a health professional that they had angina or coronary heart disease

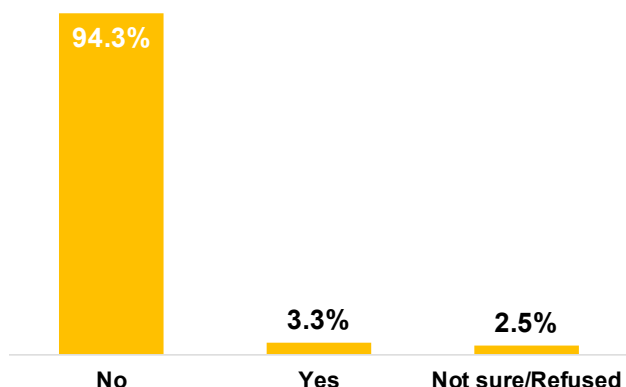


Of the 2,209 respondents, 2.9% were told that they had angina or coronary heart disease.

STROKE

Figure 51

Ever been told by a health professional that they had a stroke

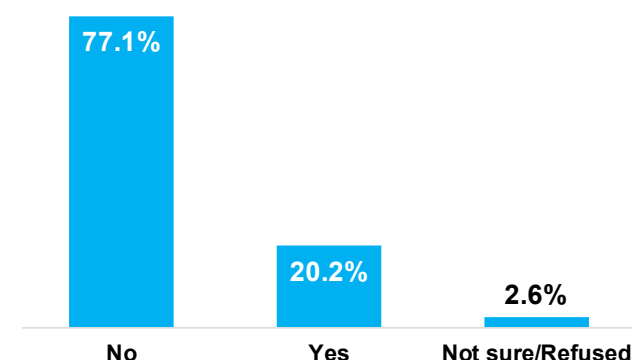


Of the 2,209 respondents, less than five percent were told that they had a stroke.

ASTHMA

Figure 52

Ever been told by a health professional that they had asthma

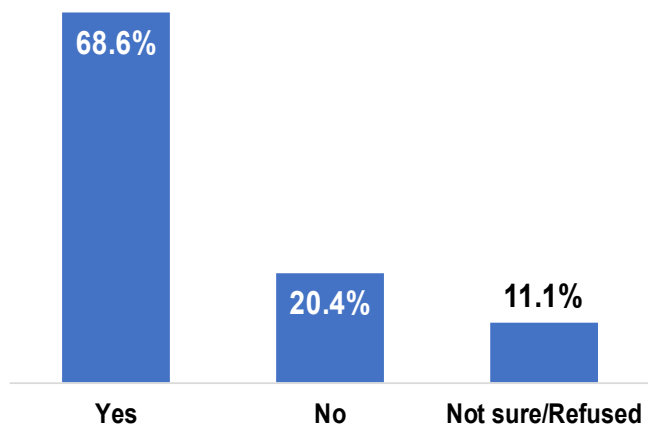


Of the 2,209 respondents, 20.2% reported they had been told by a health professional that they had asthma.

STILL HAVE ASTHMA

Figure 53

Ever been told by a health professional that they still had asthma

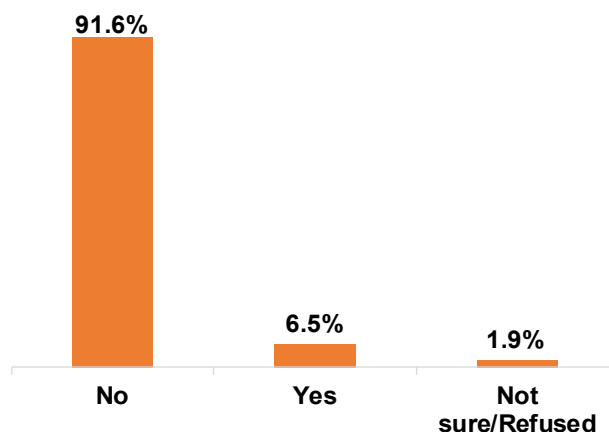


Of the 407 respondents who reported that they were ever told by a medical professional that they had asthma, 68.6% said that they still had asthma.

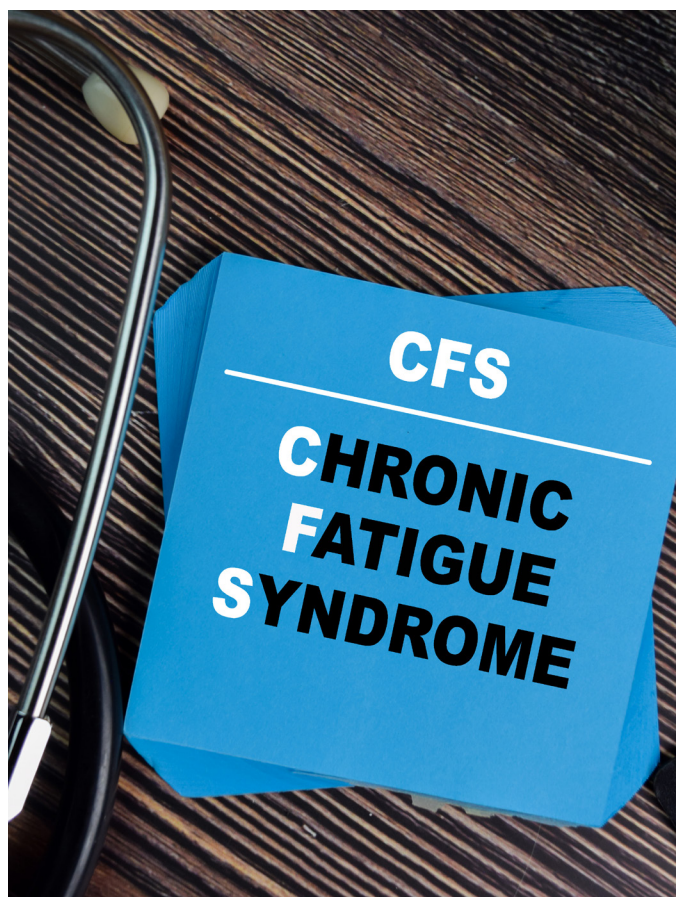
SKIN CANCER AND OTHER CANCER

Figure 54

Ever been told by a health professional that they had skin cancer and other types of cancer



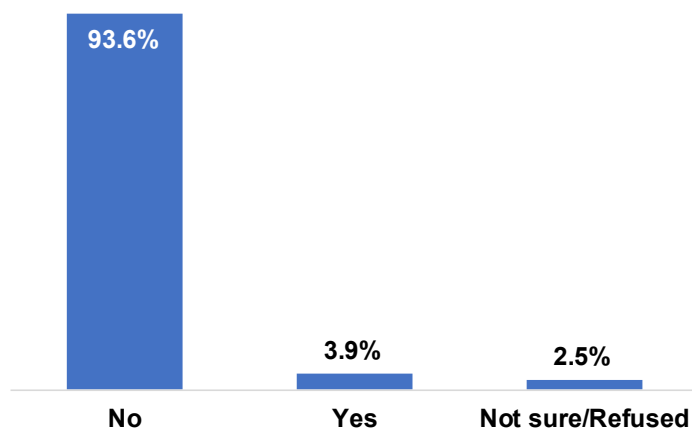
Of the 2,209 respondents, 6.5% had been told they had cancer.



COPD, EMPHYSEMA, AND CHRONIC BRONCHITIS

Figure 55

Ever been told by a health professional they had Chronic Obstructive Pulmonary Disease (COPD), emphysema, or chronic bronchitis

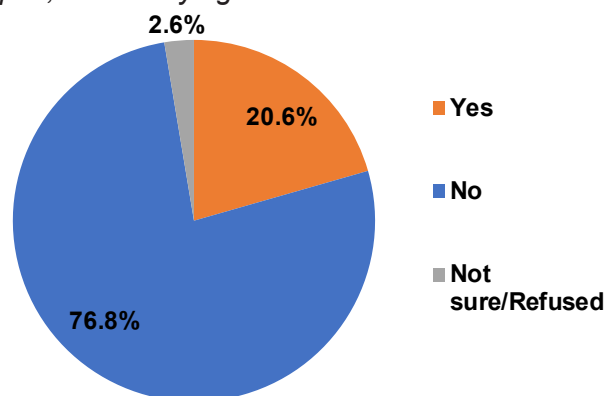


Of the 2,209 respondents, less than five percent were told, by a health professional, they had COPD, emphysema or chronic bronchitis.

ARTHRITIS

Figure 56

Ever been told by a health professional that they had arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia

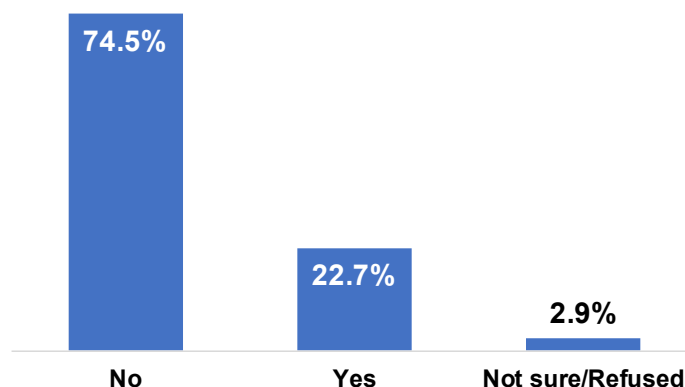


Of the 2,209 respondents, 20.6% of respondents were told they had arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia by a health professional.

DEPRESSION

Figure 57

Ever been told by a health professional they had a depressive disorder

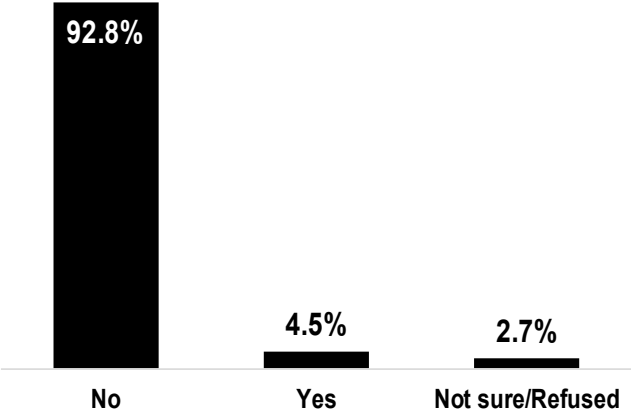


Of the 2,209 respondents, 22.7% were told they had a depressive disorder (i.e., depression, major depression, dysthymia, or minor depression).

KIDNEY DISEASE

Figure 58

Ever been told by a health professional that they had kidney disease



Of the 2,209 respondents, less than five percent were told they had kidney disease.



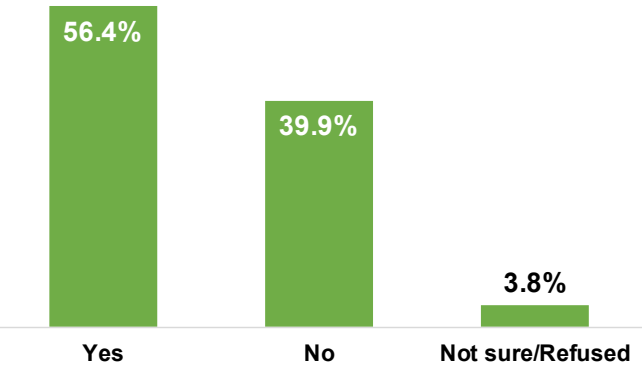
DIABETES

According to the CDC, the AIAN population are at greater risk of having diabetes than any other United States racial group. Diabetes is the leading cause of kidney failure, a costly condition that requires dialysis or kidney transplant for survival. Kidney failure can be delayed or prevented by controlling blood pressure and blood sugar and by taking medicines that protect the kidneys. Getting care for diabetes is an essential measure for regular kidney testing and learning about kidney disease and treatment. Although kidney failure from diabetes among the AIAN population was the highest of any race, prevalence rates have decreased, especially since Indian Health Service (IHS) began using population health and team-based approaches to diabetes and kidney care, a potential model for other populations.¹⁴

TESTED FOR DIABETES

Figure 59

Were tested for diabetes within the last three years

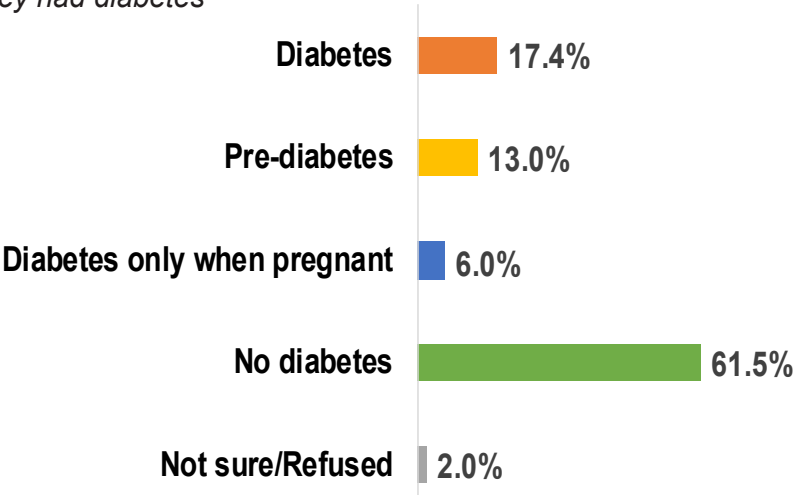


Of the 2,209 respondents, 56.4% had a diabetes test within the last three years.

DIABETES DIAGNOSIS

Figure 60

Ever been told by a health professional that they had diabetes



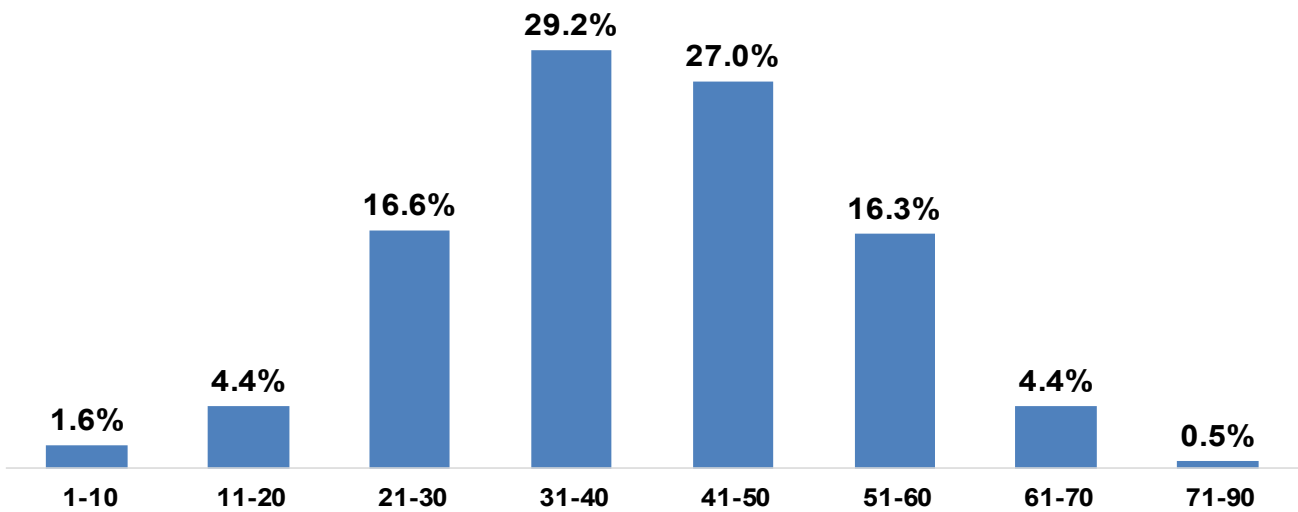
Among the 2,209 respondents, 17.4% were told they had diabetes and 13.0% said they had borderline or pre-diabetes. In addition 6.0% said that they had diabetes or pre-diabetes only when they were pregnant.



AGE OF DIABETES DIAGNOSIS

Figure 61

Were first diagnosed with diabetes by age group

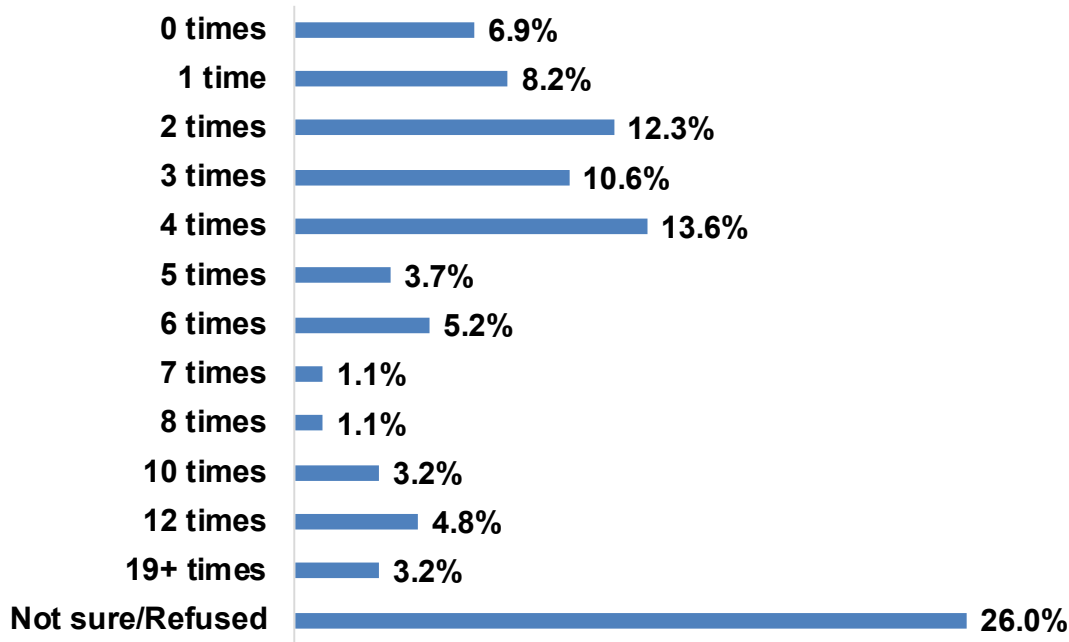


Of the 367 respondents, who ever were ever told by health professional they had diabetes, 29.2% were between 31-40 years old and 27.0% were between 41-50 years old (missing = 95).

DIABETES VISIT FREQUENCY

Figure 62

Were seen by a doctor, nurse, or other health professional for diabetes (number of times)

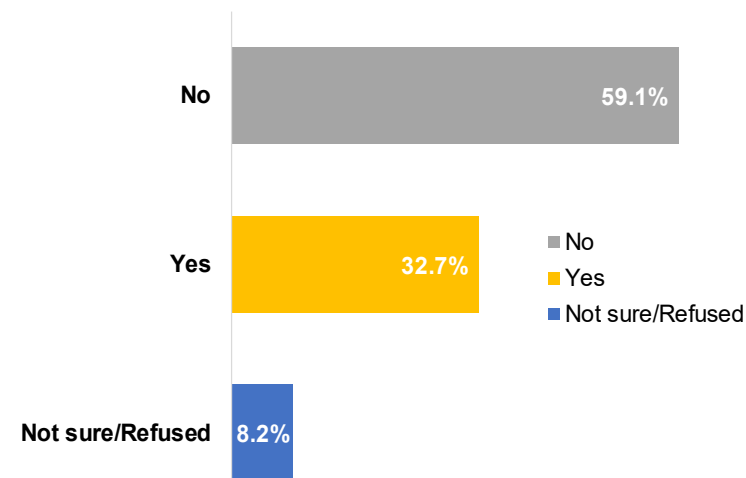


Of the 462 respondents who were ever told that they had diabetes, 13.6% reported that they saw a health professional at least at least four times, followed by those who said they saw a health professional two times (12.3%) in the past 12 months.

INSULIN

Figure 63

Had used insulin to manage their diabetes



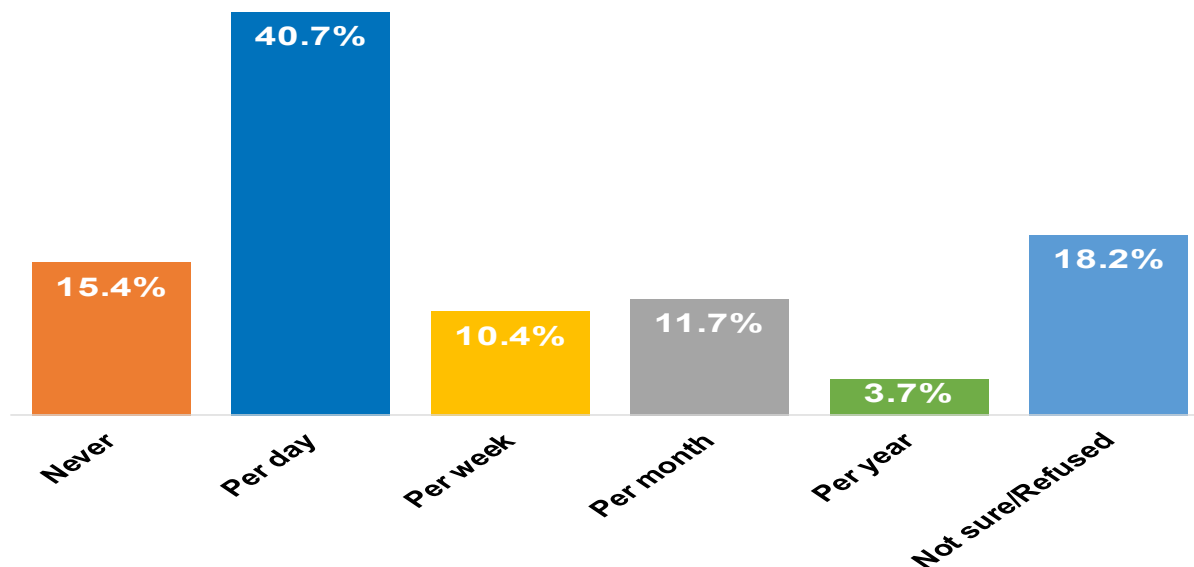
Of the 462 respondents who reported they had diabetes, 32.7% said they were taking insulin to manage their diabetes.



BLOOD SUGAR TESTING

Figure 64

Had checked for blood sugar levels by time

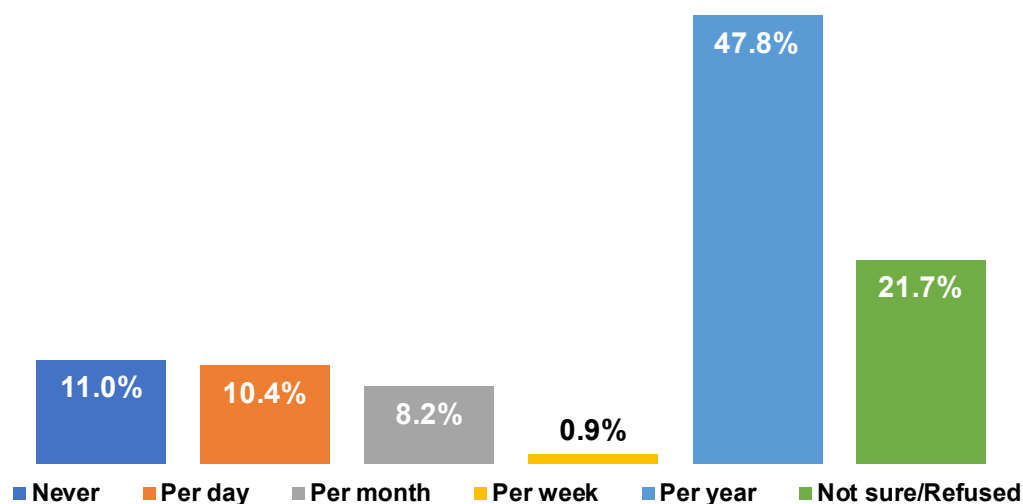


Of the 462 respondents who reported they had diabetes, 15.4% did not check their blood sugar levels.

A1C TESTING

Figure 65

Were tested for their A1C level

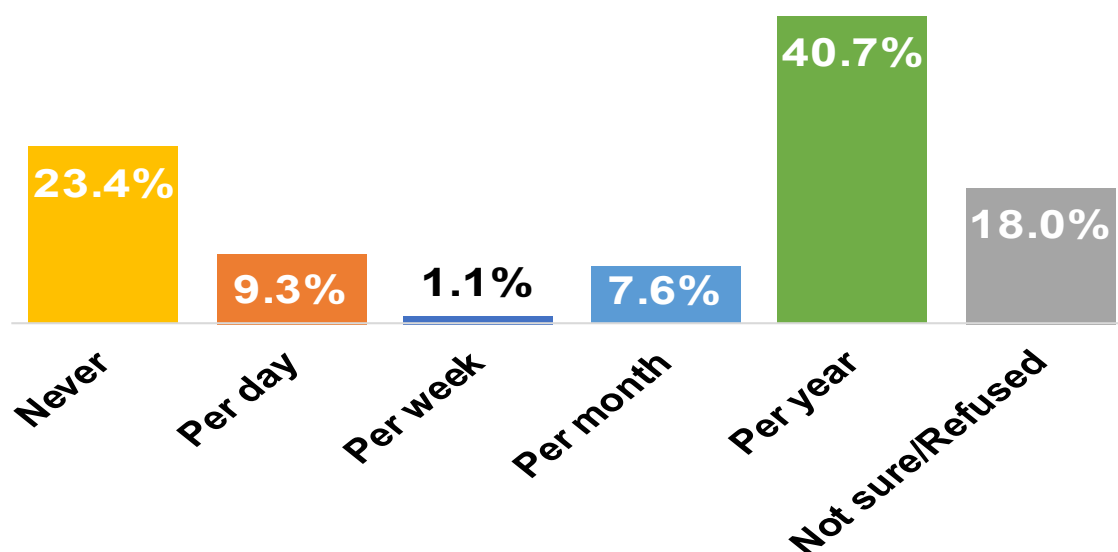


Of the 462 respondents who reported they had diabetes, 47.8% of the respondents had their A1C level checked at least once per year.

SORES CHECK

Figure 66

Were seen by a doctor or health professional for sores in the past 12 months

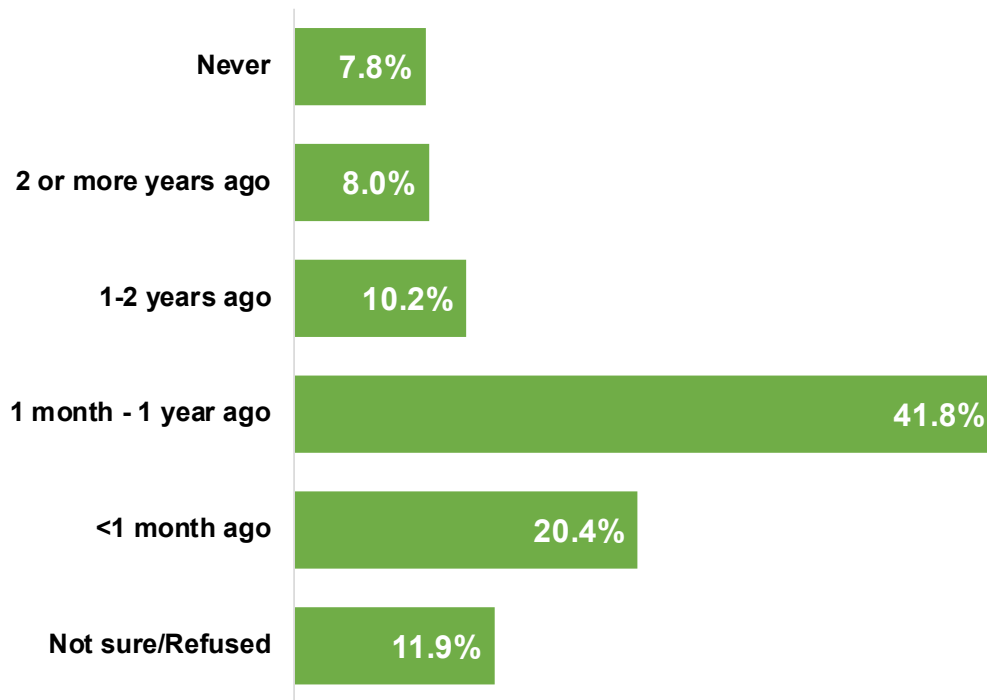


Of the 462 respondents who reported they had diabetes, 23.4% were not seen by a doctor to check for sores in the past 12 months.

EYE DILATION AND DIABETES

Figure 67

Had their eyes dilated within the past 12 months

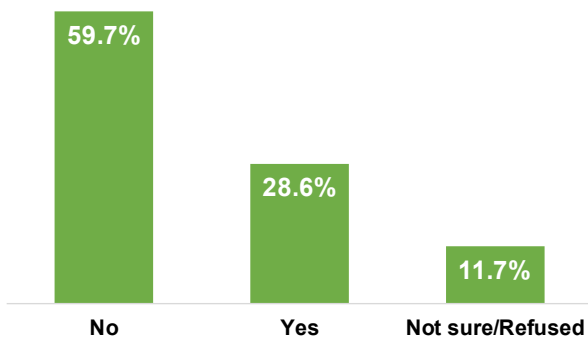


Of the 462 respondents who said they had diabetes, almost thirty percent had not had their eyes dilated in the last 12 months.

DIABETES AFFECT ON VISION

Figure 68

Were told by a doctor that their diabetes affected their eyes or had retinopathy

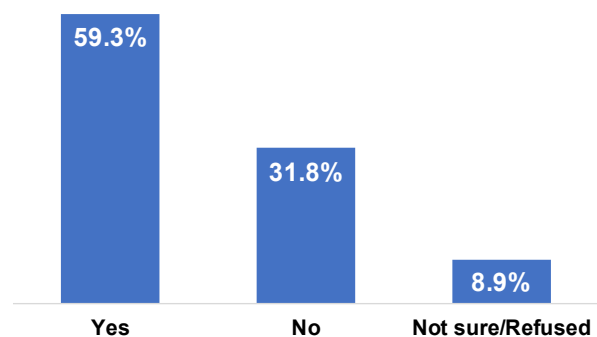


Of the 462 respondents who had diabetes, 28.6% were told their eyes were affected.

DIABETES MANAGEMENT

Figure 69

Had taken a class on diabetes management



Of the 462 respondents who had diabetes, 31.8% have not taken a class on diabetes management.

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ARTHRITIS

According to the Mayo Clinic, arthritis is the swelling and tenderness of one or more joints. Stiffness and pain worsen with age. The two most common types of arthritis are osteoarthritis and rheumatoid. Osteoarthritis causes tissues to cover the ends of the bones where they form a joint to break down. Rheumatoid arthritis attacks the joints.¹⁵

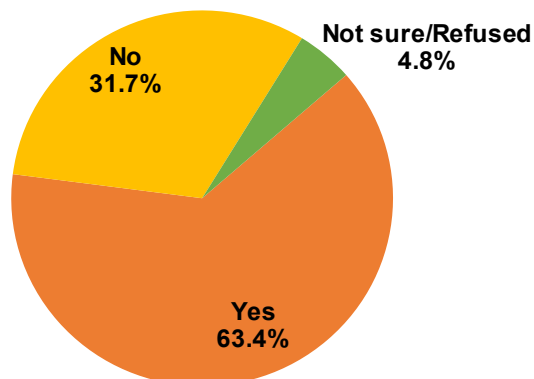
According to researchers, AIANs have the highest prevalence of arthritis in the United States compared to other races. There are not enough programs in rural areas available to manage chronic conditions like arthritis. Arthritis-attributable work limitations are common among working-age adults.



MOBILITY WITH ARTHRITIS

Figure 70

Were limited in usual activities due to arthritis

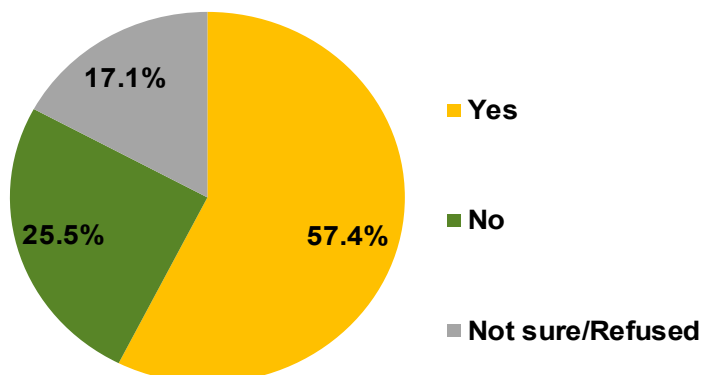


Of the 454 respondents who said they had arthritis, 63.4% said they were limited in their usual activities due to arthritis.

ARTHRITIS AND THE WORKPLACE

Figure 71

Were affected by arthritis or joint symptoms in the workplace

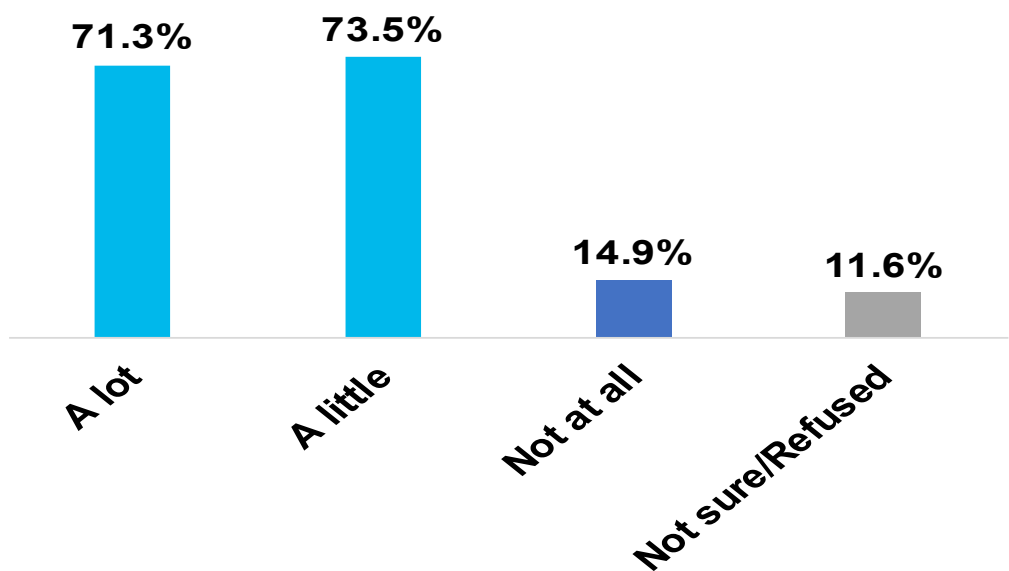


Of the 310 respondents, who reported they had arthritis and it limited their activities, 57.4% respondents reported that arthritis or joint symptoms affects them at their work.

ARTHRITIS AND SOCIAL ACTIVITIES

Figure 72

Were affected by arthritis or joint symptoms for social activities

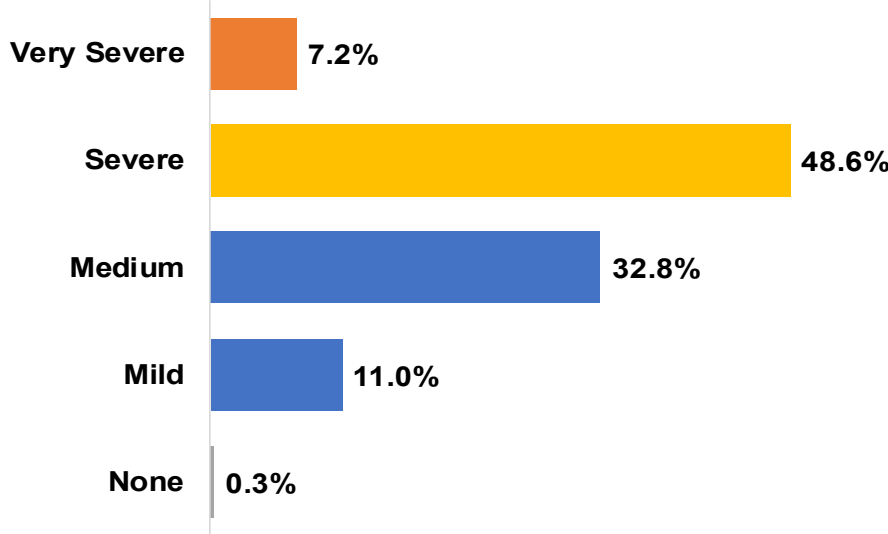


Of the 310 respondents who said they had arthritis and said it limited their activities, 71.3% greatly affected their social activities.

ARTHRITIS AND SEVERITY

Figure 73

Severity of arthritis pain



Of the 290 respondents, who said they arthritis and it limited their activies, 48.6% said their arthritis pain was severe (missing = 20).

Cancer Survivorship



CANCER SURVIVORSHIP

According to the National Cancer Institute, rates for new cancer have been falling on average 1.1% every year for the past ten years (2008-2017), with death rates also seeing a decline of an average of 1.5% each year over 2008-2017.¹⁶

Identifying factors associated with optimal physical, emotional, and social well-being among cancer patients, can help survivors and caregivers to improve their quality of life.¹⁶

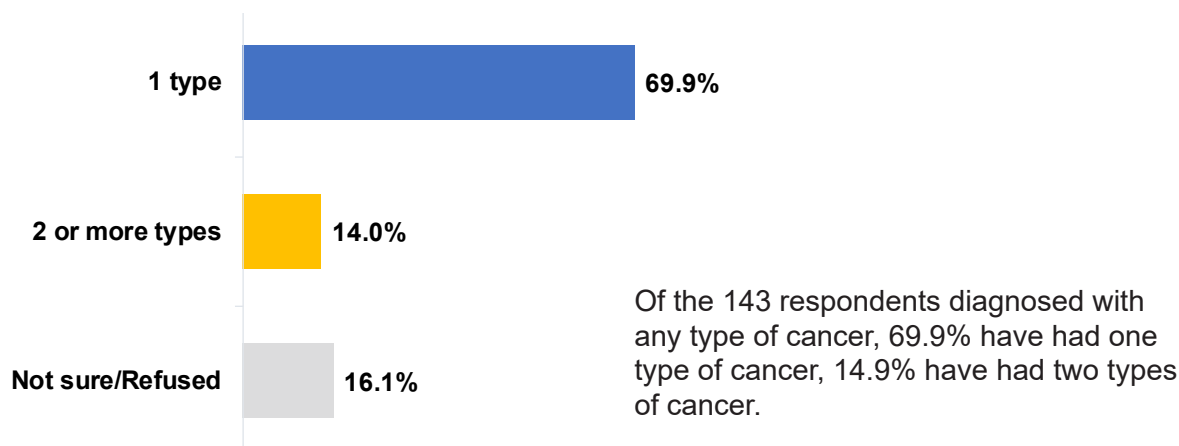
According to some studies, AIANs have the lowest 5-year relative survival rate for all cancers combined and are more likely to die compared to whites. Statistics on cancer incidence, mortality, and survival provide estimates of the number of AIANs diagnosed with cancer and length of survival, but they are not informative for estimating the impact of the diagnosis on survivors' daily lives, their families, and communities.¹⁷



TYPES OF CANCERS

Figure 74

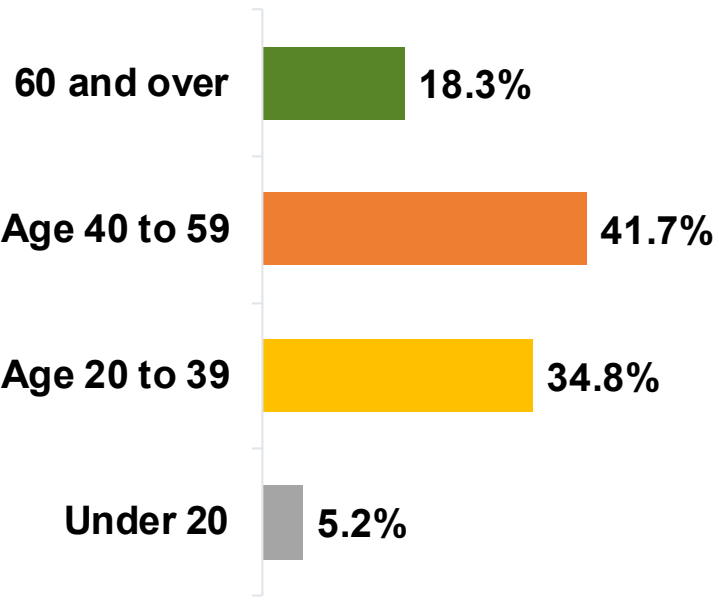
Types of cancer



CANCER AGE

Figure 75

Had been diagnosed by age-group

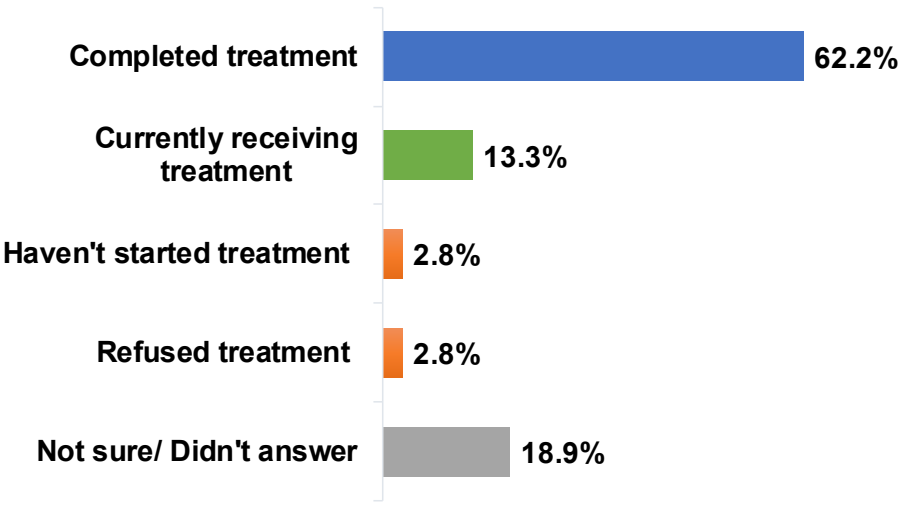


Of the 115 respondents diagnosed with any type of cancer, 41.7% were between 40 and 59 (missing = 28).

CANCER AND TREATMENT

Figure 76

Were currently receiving cancer treatment



Of the 143 diagnosed with any type of cancer, 62.2% have completed treatment and 13.3% are currently receiving treatment.

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Substance Abuse



SUBSTANCE ABUSE

Abuse of substances leads to a buildup of tolerance to the effects, which increases the risk of dependence and addiction.

Risk factors that increase the likelihood of becoming addicted to drugs are the age of first use, type of drug, addictive properties, genetic predisposition, psychological factors, and substance use or addiction in the family or among peers.¹⁸

While only current behaviors are explored in this survey, risk factors are important considerations for prevention and intervention when working with substance abuse.

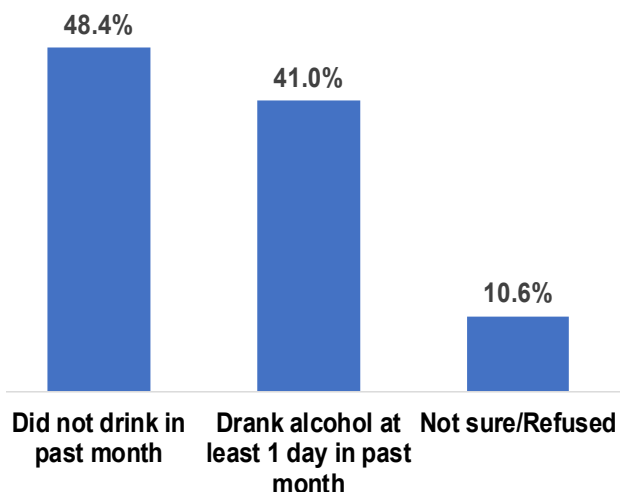
ALCOHOL



ALCOHOL USE

Figure 77

Had at least one drink in the past 30 days such as beer, wine, malt beverage, or liquor

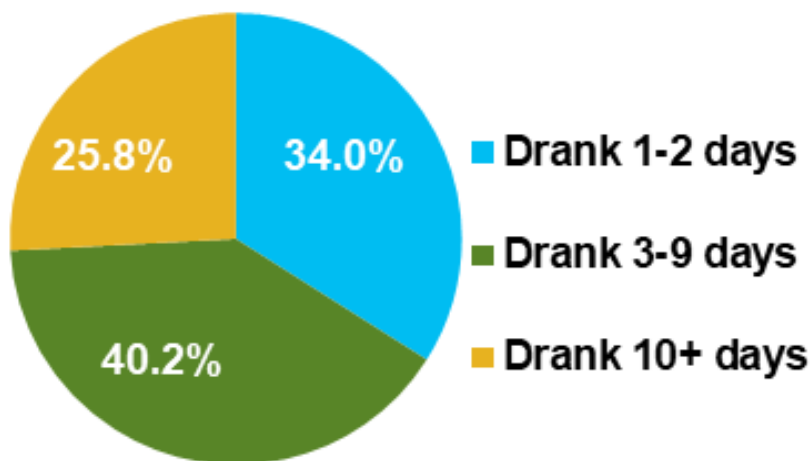


Out of the 1,614 respondents, who ever had an alcoholic beverage, 41.0% said that during the past 30 days they had at least one drink.

NUMBER OF DRINKS IN THE PAST 30 DAYS

Figure 78

Number of days used alcohol

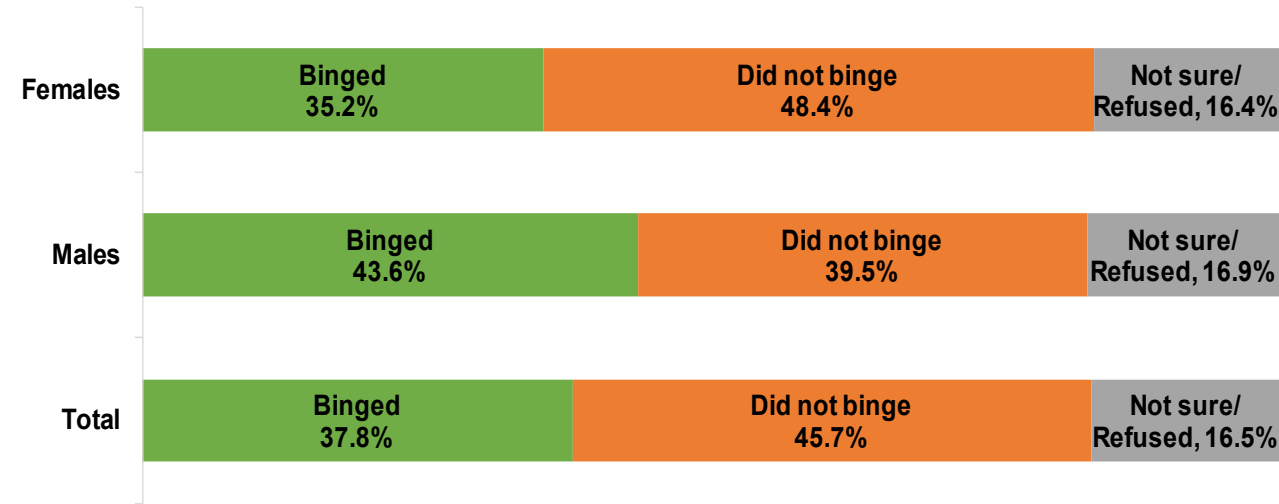


Of the 662 respondents who reported they had at least one drink in the past 30 days, 40.2% said they drank on three to nine of the past 30 days.

BINGE DRINKING BY GENDER

Figure 79

Binge drank alcohol on an occasion by gender

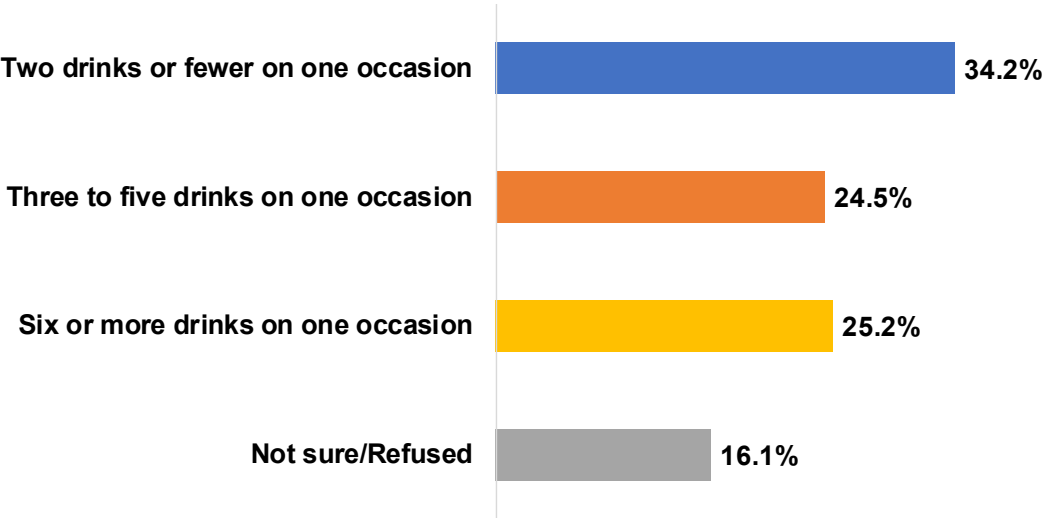


Among the 662 respondents, who drank at least one day in the past month, 37.8% binge drank in the past 30 days. 43.6% of male respondents reported binge drinking (defined as five or more drinks for men) and 35.2% of female respondents reported binge drinking (four or more drinks for women).

LARGEST NUMBER OF DRINKS

Figure 80

Largest number of drinks consumed in the past 30 days on any occasion



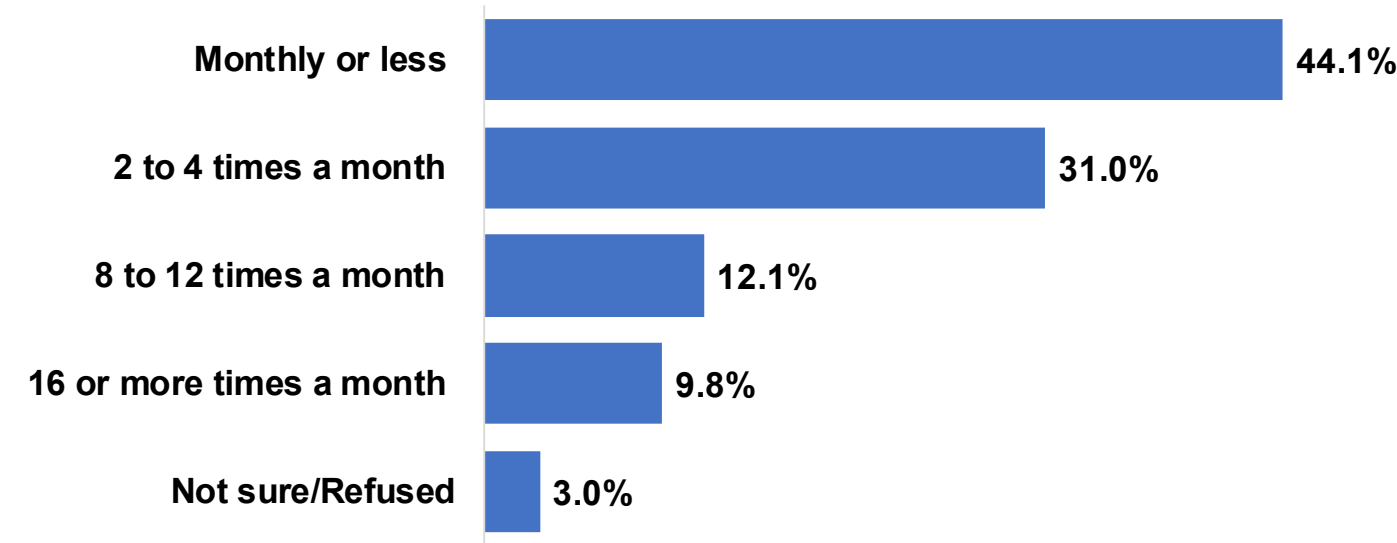
Of the 662 respondents, who reported they drank in the past month, nearly half had three or more drinks on one occasion.



FREQUENCY OF ALCOHOL USE

Figure 81

Frequency of alcoholic use

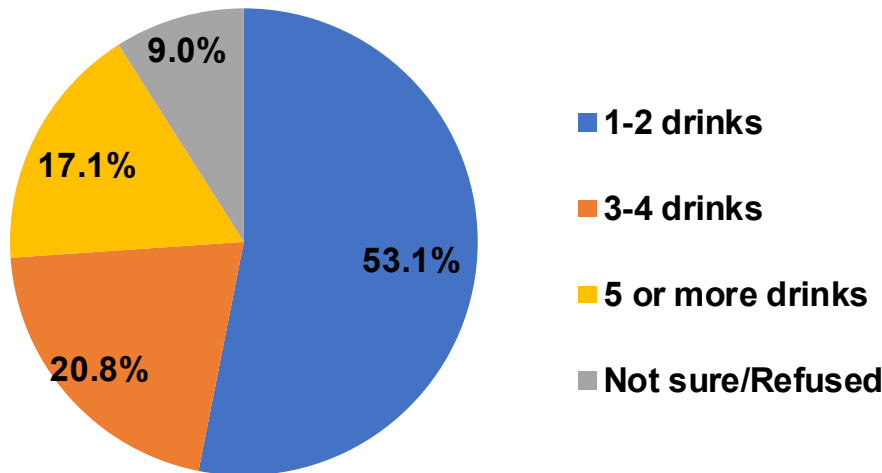


Of the 662 respondents that reported how often they drank alcohol, about ten percent reported they drank 16 or more times per month.

AMOUNT CONSUMED ON DAY WHEN DRINKING

Figure 82

Amount of drinks consumed on day when drinking

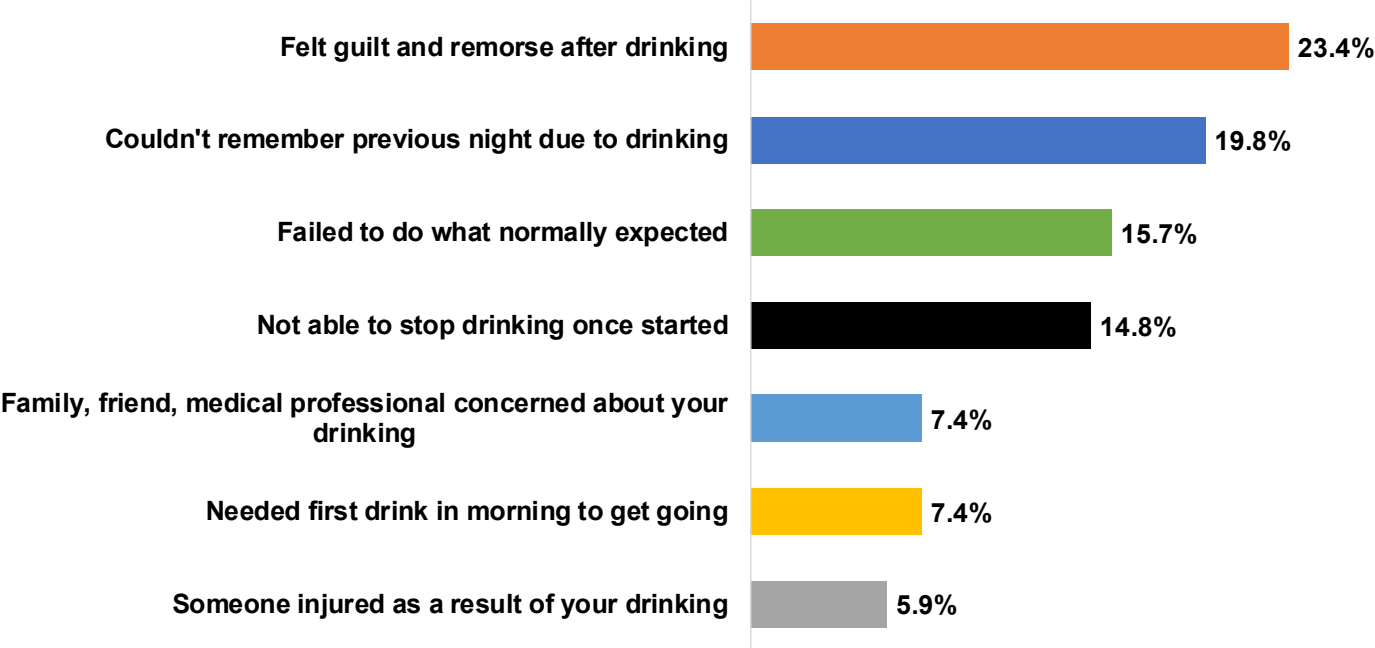


Of the 644 respondents, who drank in the past month, 53.1% consumed one to two drinks during a typical day (missing = 18).

DRINKING CONSEQUENCES

Figure 83

Consequences as a result of drinking



Of the 644 respondents, who drank at least one day in the past month, about twenty percent felt guilt or could not remember the previous night (missing = 18).



DRUGS

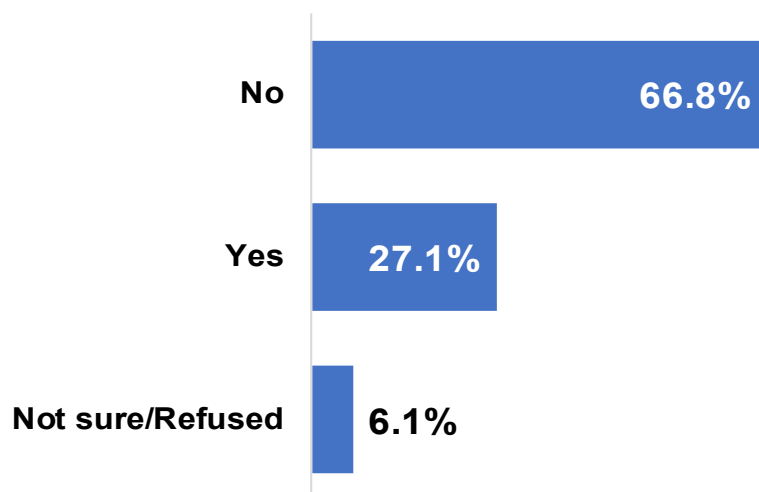
The prevalence of substance abuse is well known for individuals in the general population level and across subgroups of the population. However, except for alcohol, substance use is more prevalent among AIAN populations than among white populations. According to IHS, substance use disorders result in devastating intergenerational social, economic, physical, mental, and spiritual health disparities in AIAN communities.¹⁹



ILLEGAL DRUG USAGE

Figure 84

Had used an illegal drug or a prescription medication for non-medical reasons in the past year

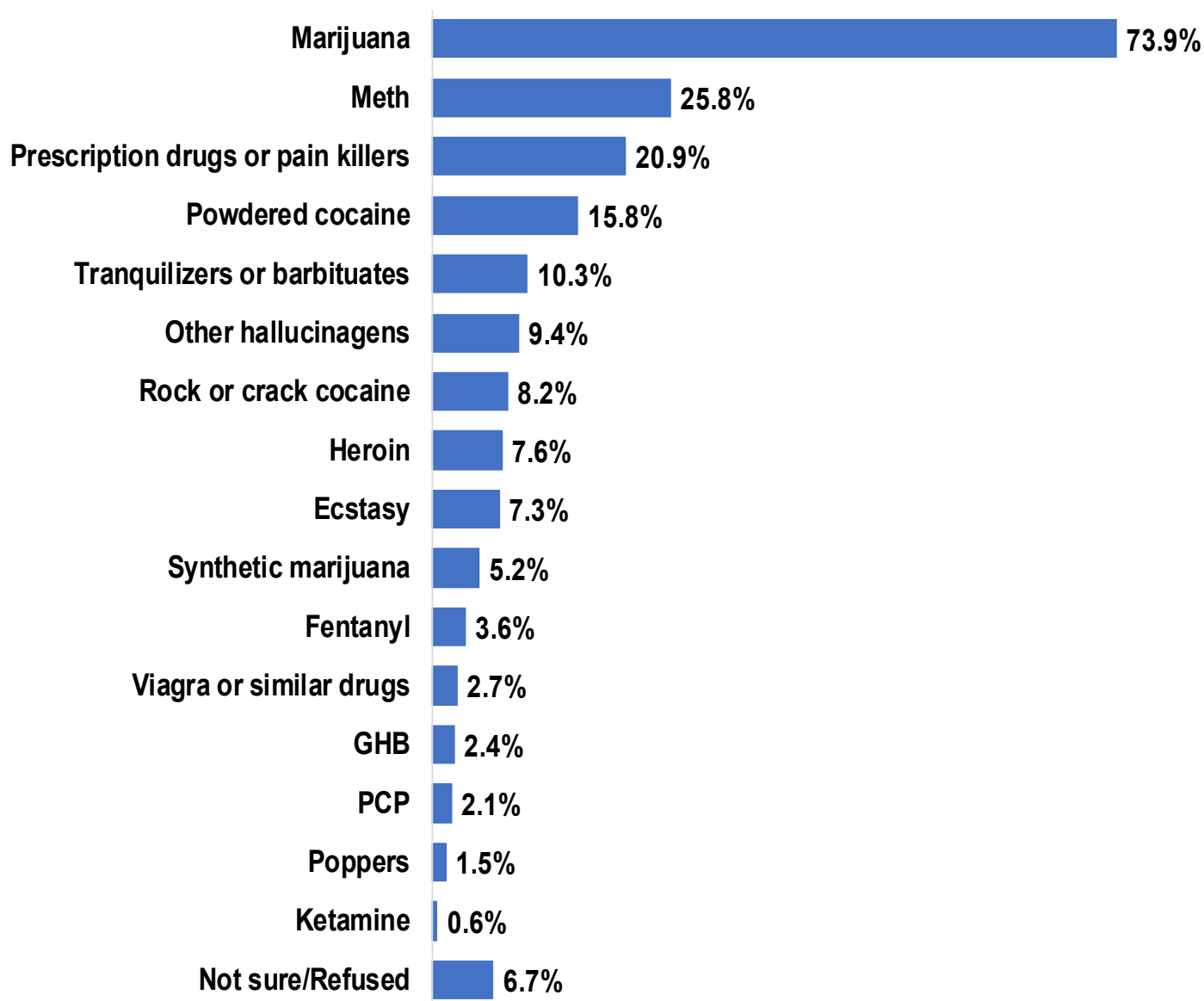


Of the 2,209 respondents, 27.1% said they used an illicit drug or prescription for non-medical reasons.

ILLICIT DRUGS

Figure 85

Types of illicit drugs used



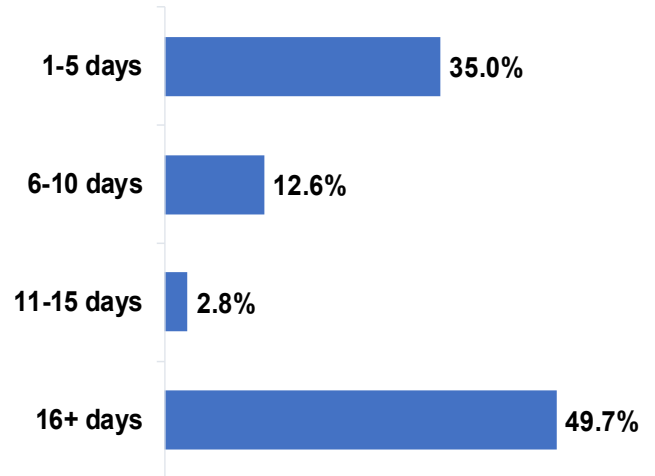
Of the 330 respondents, who have ever used an illicit drug, 73.9% used marijuana, followed by meth and prescription drugs (25.8%, 20.9%, respectively), within the past year (missing = 332). Multiple choices were allowed, therefore the total will not equal 100%.



MARIJUANA USAGE

Figure 86

Number of days marijuana or hashish was used in the past 30 days

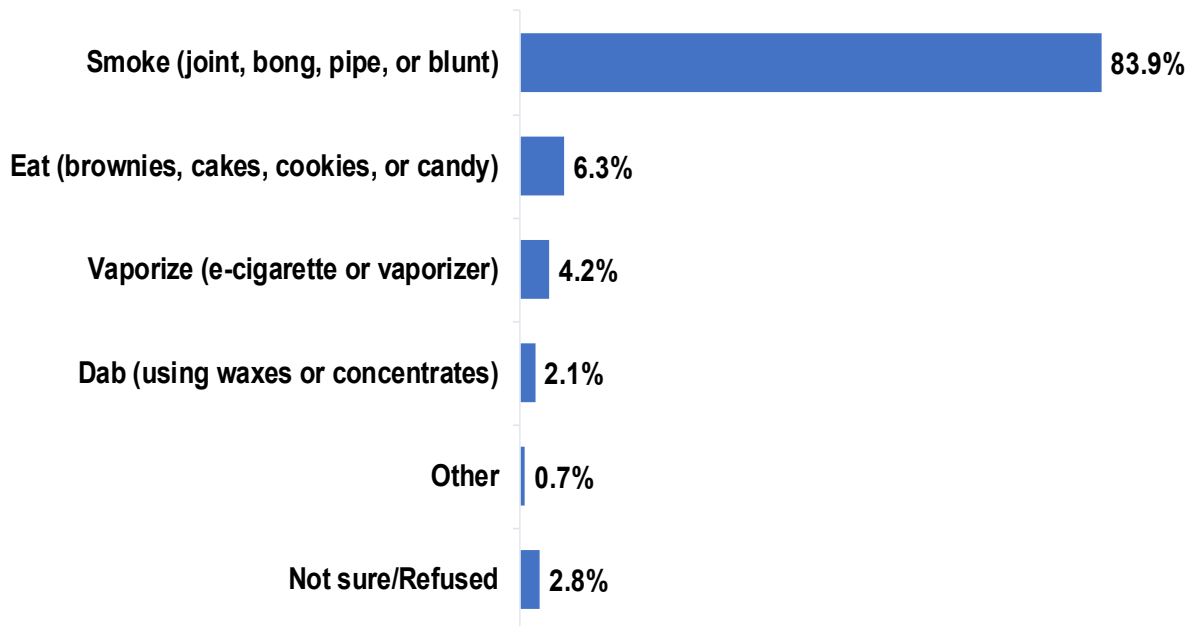


Of the 143 respondents that reported using marijuana or hashish in the past 30 days, almost one-half used it on 16 or more of the past 30 days.

MARIJUANA INTAKE DEVICE

Figure 87

Marijuana intake device

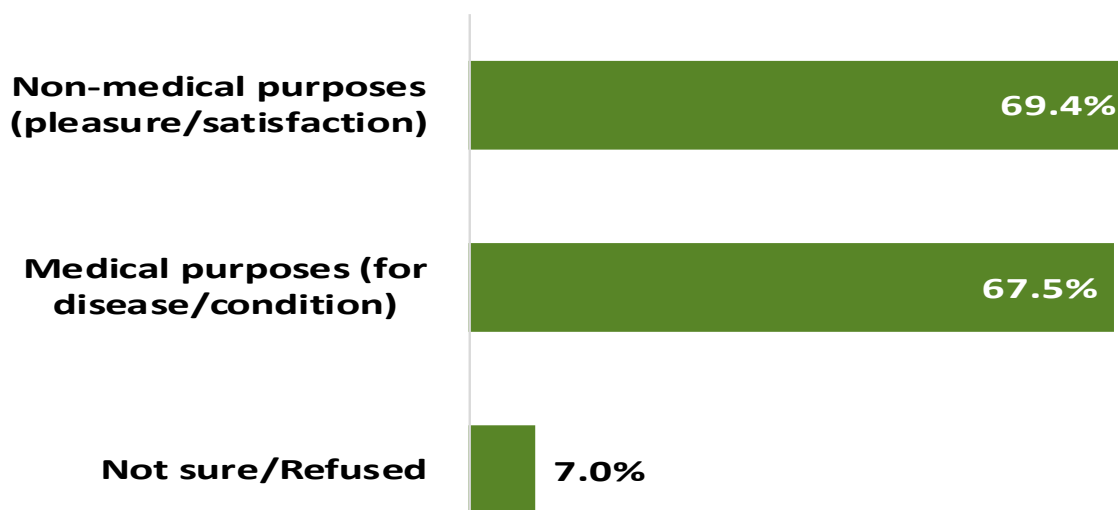


Of the 143 respondents, who used marijuana in the past 30 days, 83.9% smoked it.

MEDICAL/NON-MEDICAL MARIJUANA USE

Figure 88

Reason for using marijuana or hashish during the past 30 days

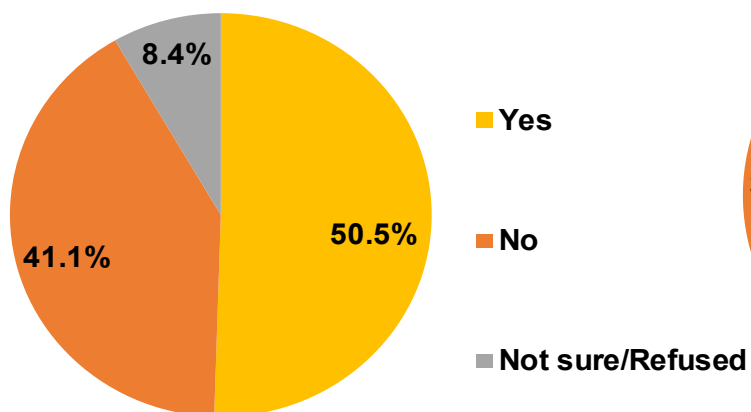


Among 143 respondents who reported using marijuana in the past 30 days, 69.4% used it for non-medical purposes only. Totals will not equal 100% since some respondents used marijuana for medical and non-medical purposes.

NON-MEDICAL USE

Figure 89

Had used drugs other than those required for medical reasons

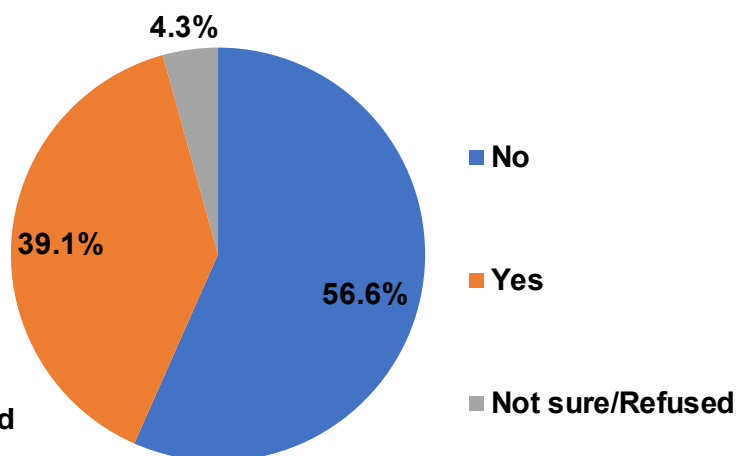


Among the 598 participants who reported they ever used illicit drugs, 50.5% used drugs other than those required for medical reasons.

ILLICIT ACTIVITIES

Figure 90

Had engaged in illegal activities to obtain drugs

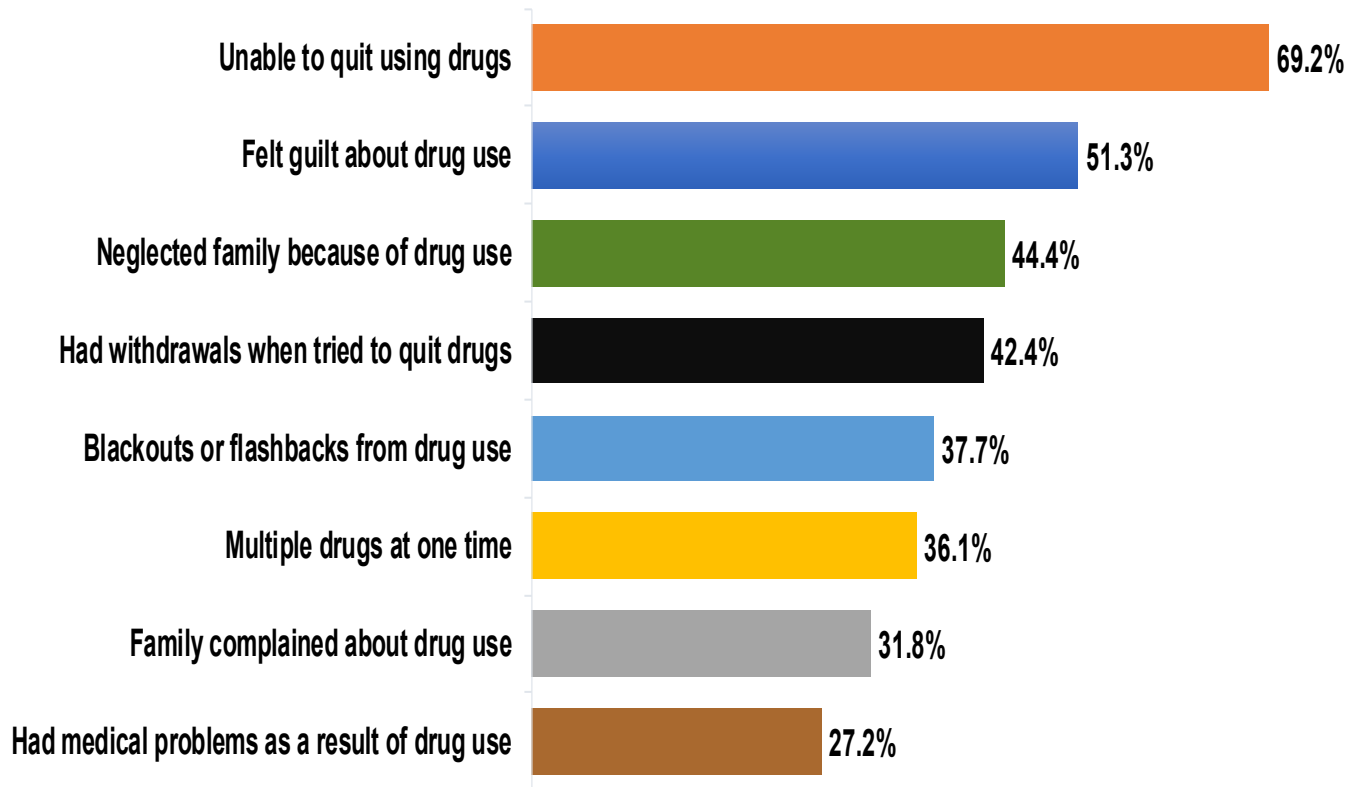


Of the 302 respondents who reported they used drugs other than those required for medical reasons, 39.1% reported they had engaged in illegal activities in order to obtain drugs.

NON-MEDICAL DRUG USE

Figure 91

Consequences of using drugs other than those required for medical reasons



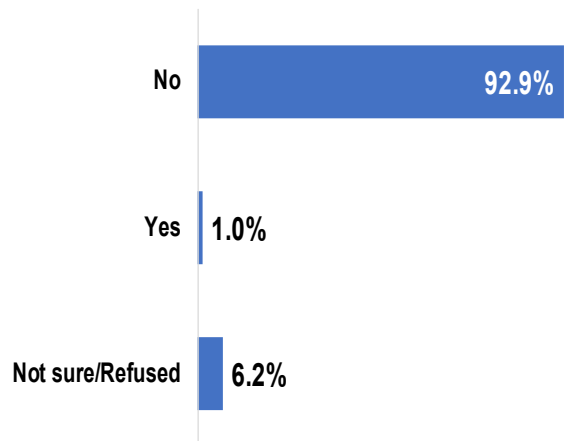
Among the 302 respondents who used drugs other than those required for medical reasons, 69.2% were unable to quit using drugs. Just over half felt guilty about drug use.



DRUGS AND SEX

Figure 92

Had received money or drugs in exchange for sex in the past year



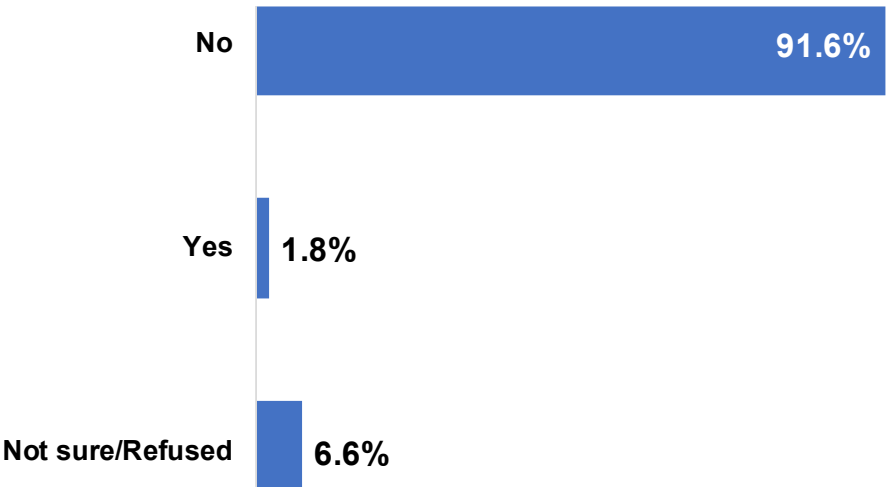
Of the 2,209 respondents, less than five percent said they had received money or drugs in exchange for sex in the past year.



OTHER DRUG INJECTION

Figure 93

Had a drug injected other than prescription in the past year



Of the 2,209 respondents, less than five percent reported that they injected a drug (other than prescription) in the past year.

TOBACCO USE

According to the CDC, tobacco use leads to disease, disability, and harms nearly every organ of the body. More than 16 million Americans are living with a disease caused by smoking. For every person who dies because of smoking, at least 30 people live with a serious smoking-related illness. Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases the risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis.²⁰

Secondhand smoke exposure contributes to approximately 41,000 deaths among non-smoking adults and 400 deaths in infants each year. Children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, middle ear disease, more severe asthma, respiratory symptoms, and slowed lung growth.²⁰

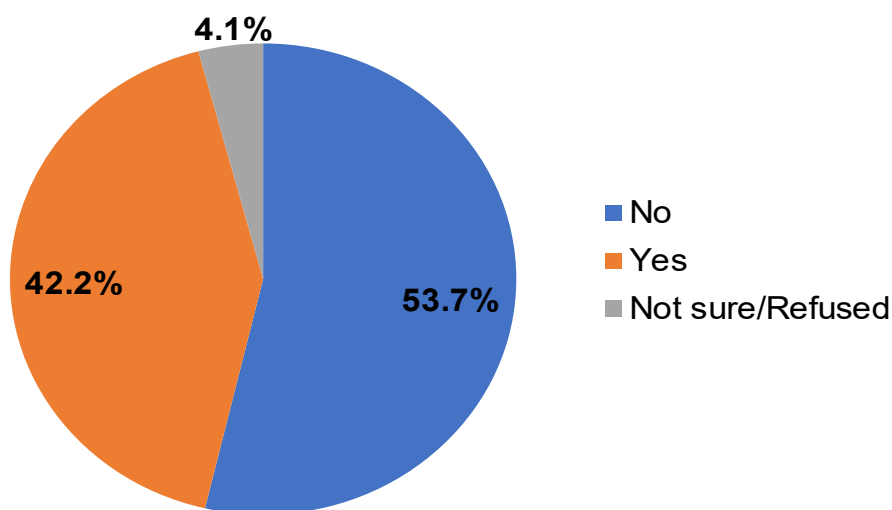
AIANs have the highest prevalence of cigarette smoking compared to all other racial/ethnic groups in the United States. Some American Indians use tobacco for ceremonial, religious, or medicinal purposes. For this reason, it is important to make the distinction between commercial and traditional tobacco use.²¹



SMOKING IN LIFETIME

Figure 94

Had smoked at least 100 cigarettes during lifetime

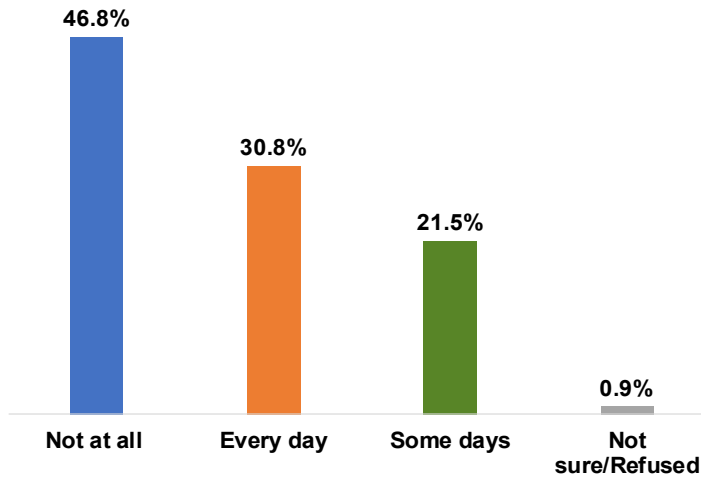


Of the 2,209 respondents, 42.2% had smoke at least 100 cigarettes in their lifetime.

SMOKING USAGE PER DAY

Figure 95

Had smoked cigarettes every day, some days, or not at all

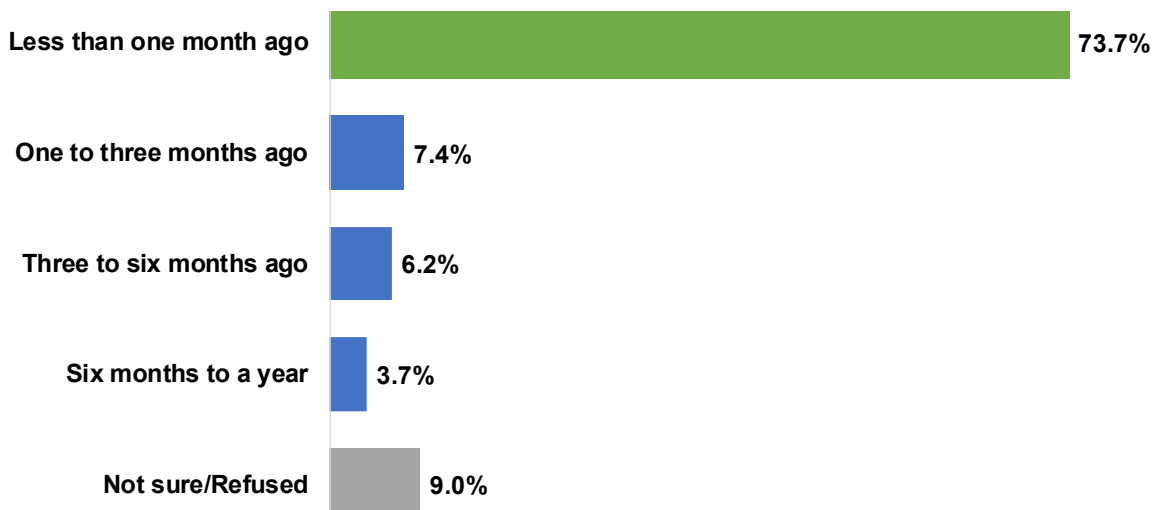


Of the 932 respondents who reported smoking at least 100 cigarettes in their lifetime, 21.5% had smoked some days and 30.8% had smoked every day.

LAST SMOKED CIGARETTE

Figure 97

Had last smoked a cigarette, even one or two puffs

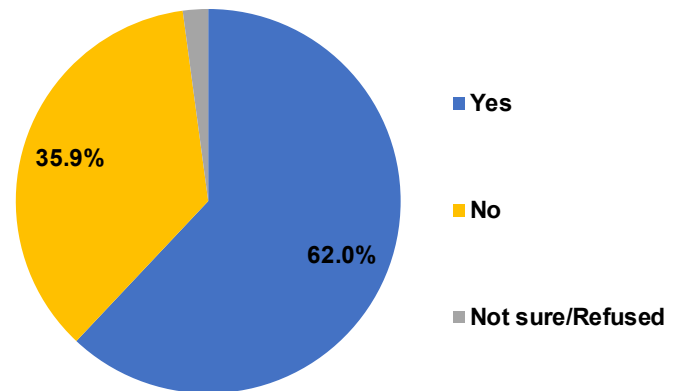


Of the 566 respondents who had at least 100 cigarettes in their life, and smoked every day or some days in the past year, 73.7% had smoked a cigarette, even one or two puffs, in the past month.

ATTEMPTS TO QUIT

Figure 96

Tried to quit smoking for one day or longer in the past 12 months

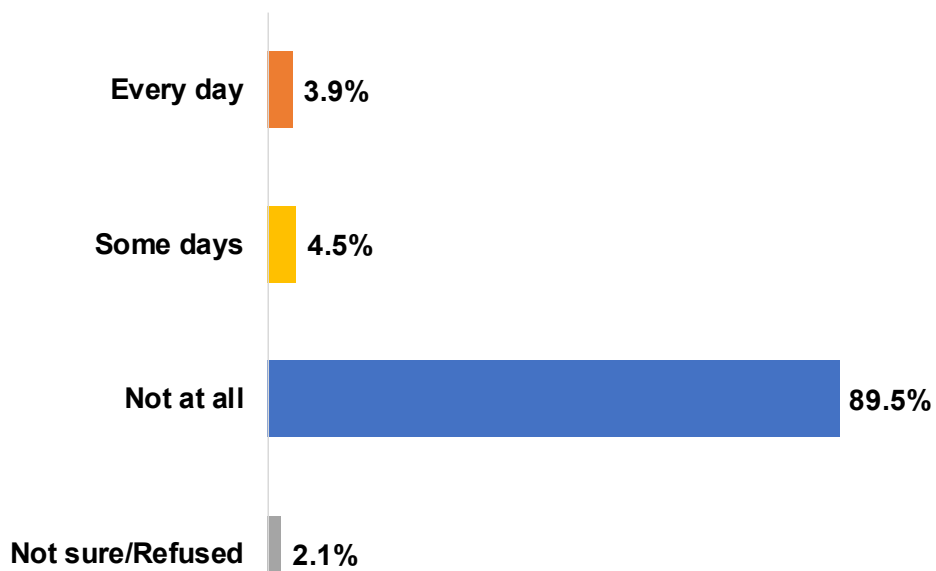


Of the 566 respondents who had at least 100 cigarettes in their life, and smoked every day or some days in the past year, 62.0% reported they had tried to quit in the past 12 months.

OTHER TOBACCO PRODUCTS

Figure 98

Were currently use chewing tobacco, snuff, or snus every day, some days, or not at all



Among the 932 respondents who had at least 100 cigarettes in their life, 8.4% use other tobacco products every day or some days.



E-CIGARETTES

E-cigarettes are known by many different names, including e-cigs, electronic nicotine delivery systems (ENDS), alternative nicotine delivery systems (ANDS), e-hookahs, mods, vape pens, vaporizers, vapes, and tank systems.

Volatile organic compounds (VOCs): At certain levels, VOCs can cause eye, nose and throat irritation, headaches and nausea, and can damage the liver, kidney and nervous system.

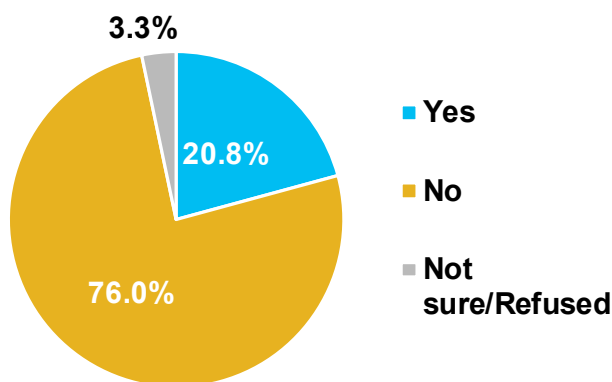
Some flavoring chemicals are more toxic than others. Studies have shown that some flavors contain different levels of a chemical called diacetyl that has been linked to a serious lung disease called bronchiolitis obliterans. Formaldehyde may be found e-cigarettes and can cause cancer. The FDA does not currently require testing of all the substances in e-cigarettes to ensure they are safe. It's also hard to know exactly what chemicals are in an e-cigarette because most products do not list all of the harmful or potentially harmful substances contained in them. Some products are also labeled incorrectly.²²



EVER USED E-CIGARETTE

Figure 99

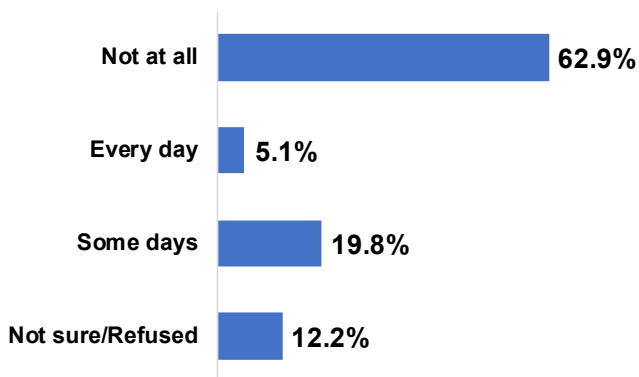
Used an e-cigarette or other electronic vaping product, even just one time in entire life



Of the 2,209 respondents, 20.8% used an e-cigarette or some form of vaping device at least one in their life.

Figure 100

Used an e-cigarettes or other electronic vaping products every day, some days, or not at all



Of the 531 respondents that said they ever used an e-cigarette, about twenty-five percent used some form of vaping device every day or some days.

VEHICLE SAFETY AND SEAT BELTS

Motor vehicle crashes are a leading cause of death among those aged 1-54 years in the United States (U.S.). Most crash-related deaths in the U.S. occur to drivers and passengers who do not wear a seat belt. For adults and older children (who are big enough for seat belts to fit properly), seat belt use is one of the most effective ways to save lives and reduce injuries in crashes. Although studies have shown that most drivers and passengers are compliant with seat belt laws, millions still do not comply and may be at risk.

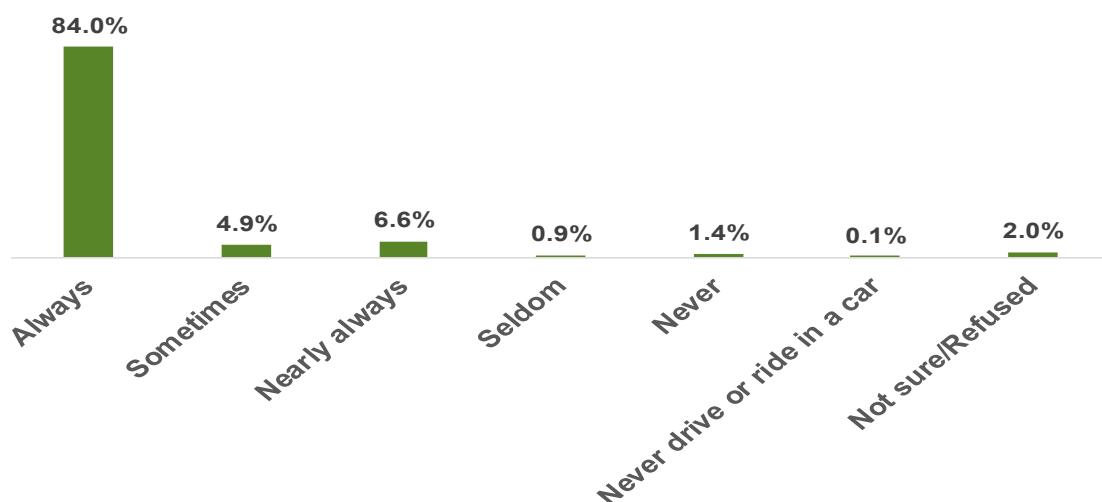
More than half (range: 51%-60%) of teens (13-19 years old) and adults aged 20-44 years old who died due to vehicle crashes in 2018 were not buckled up at the time of the crash. More than 2.2 million drivers and passengers were treated in the emergency department as the result of being injured in motor vehicle crashes in 2018.²³



SEAT BELTS

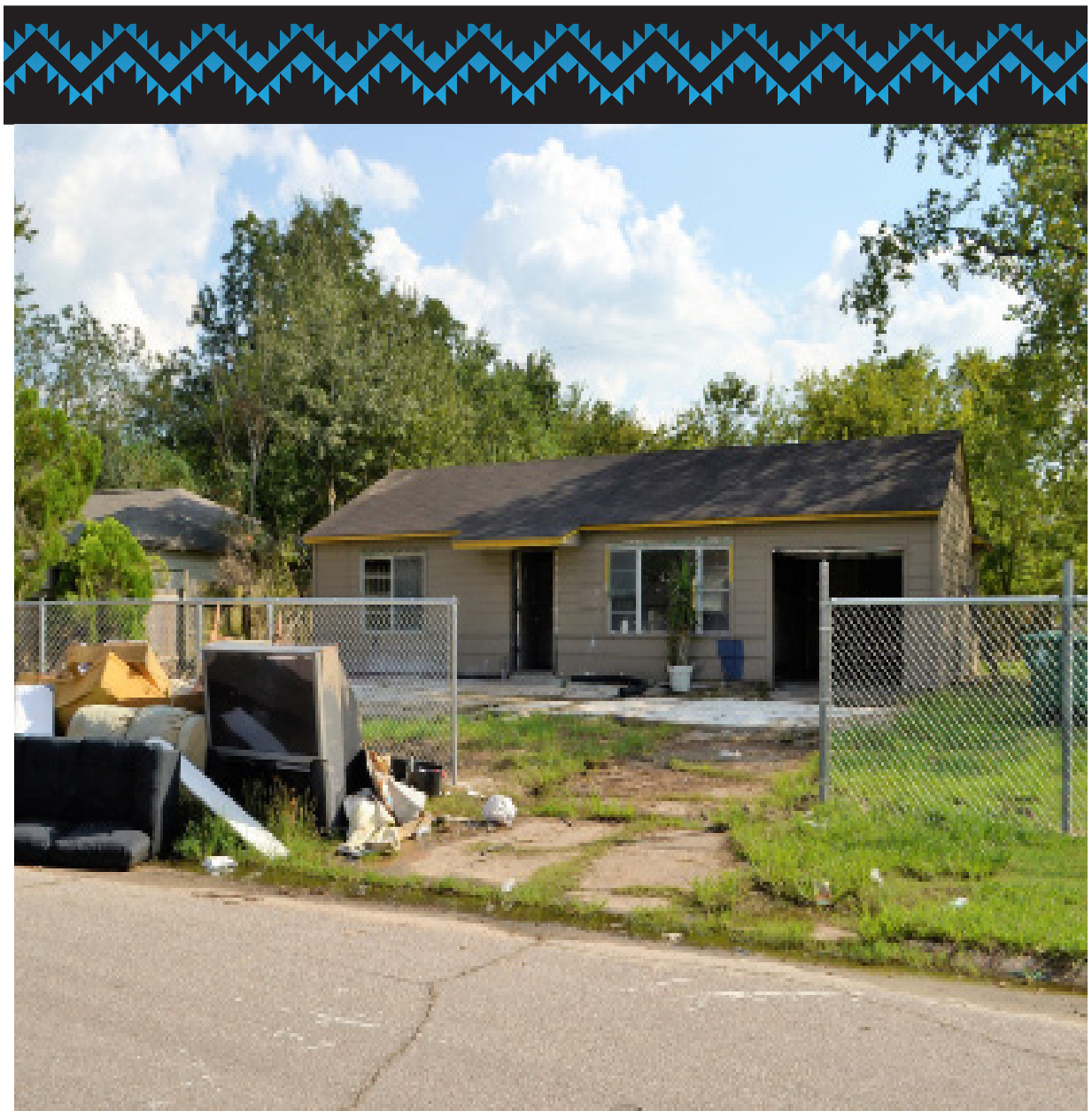
Figure 101

Had used a seat belt



Of the total respondents, 6.6% nearly always wore a seat belt and 4.9% sometimes wore a seatbelt.

Social Determinants of Health



SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the social and economic influences that impact individuals and community health and well-being. This includes conditions of where people live, learn, work, and play and can affect health behaviors and outcomes. Income, discrimination, education level, marital status, residential status, neighborhood safety, access to quality care, and insurance status are all examples of social determinants of health. Healthy homes, having stable housing and safe neighborhoods can influence physical and mental health.

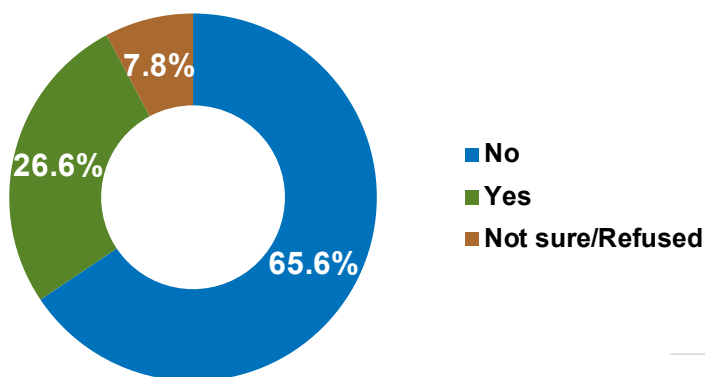
Characteristics of a neighborhood can also strongly influence health behaviors and the opportunities people have to be healthy. For example, research has found that persons who perceive their neighborhood as unsafe are less likely to be physically active.²³ In addition, unsafe neighborhoods can influence mental health and can lead to anxiety, depression, and stress, which in turn influence physical health behaviors.³ These determinants also explore economic stability and food security, or the disruption of food intake or eating patterns because of lack of money or resources.²⁴



MORTGAGE

Figure 102

Were unable to pay their mortgage, rent, or utility bills

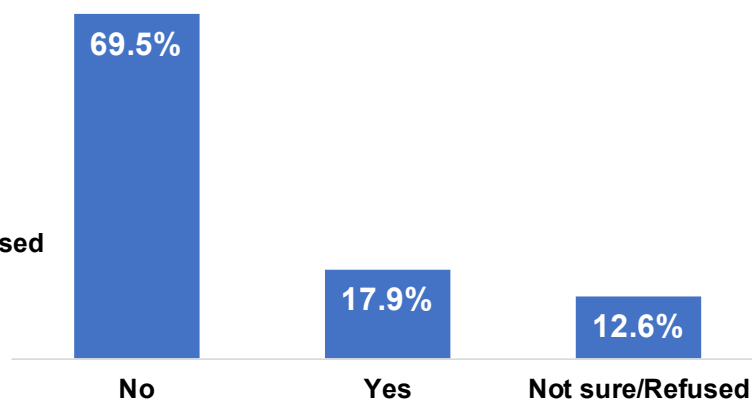


Of the 2,209 respondents, 26.6% were unable to pay their mortgage, rent, or utility bills.

MOVED IN THE PAST 12 MONTHS

Figure 103

Had moved from one home to another in the past 12 months

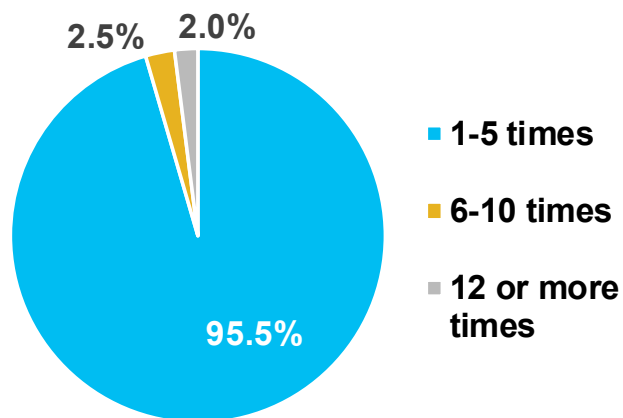


In the last 12 months, 17.9% of the 2,209 respondents moved from one home to another.

TIMES MOVED IN THE PAST 12 MONTHS

Figure 104

Times moved in the past 12 months

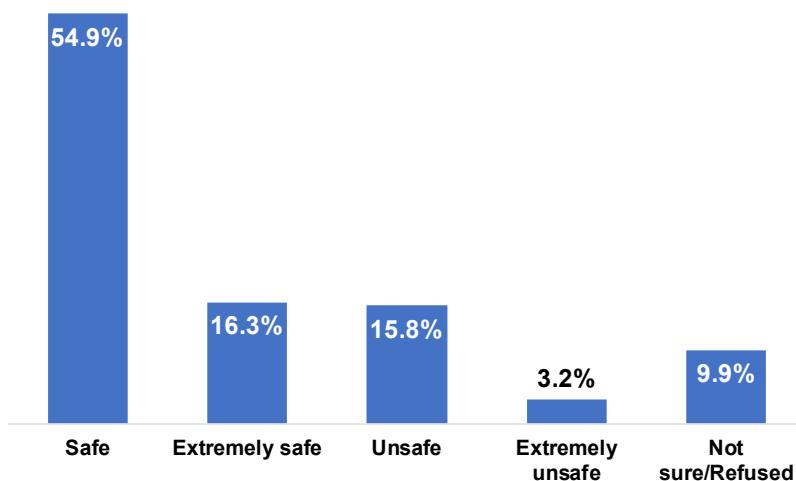


Of the 396 respondents, that reported moving in the past 12 months, less than five percent of respondents moved six or more times.

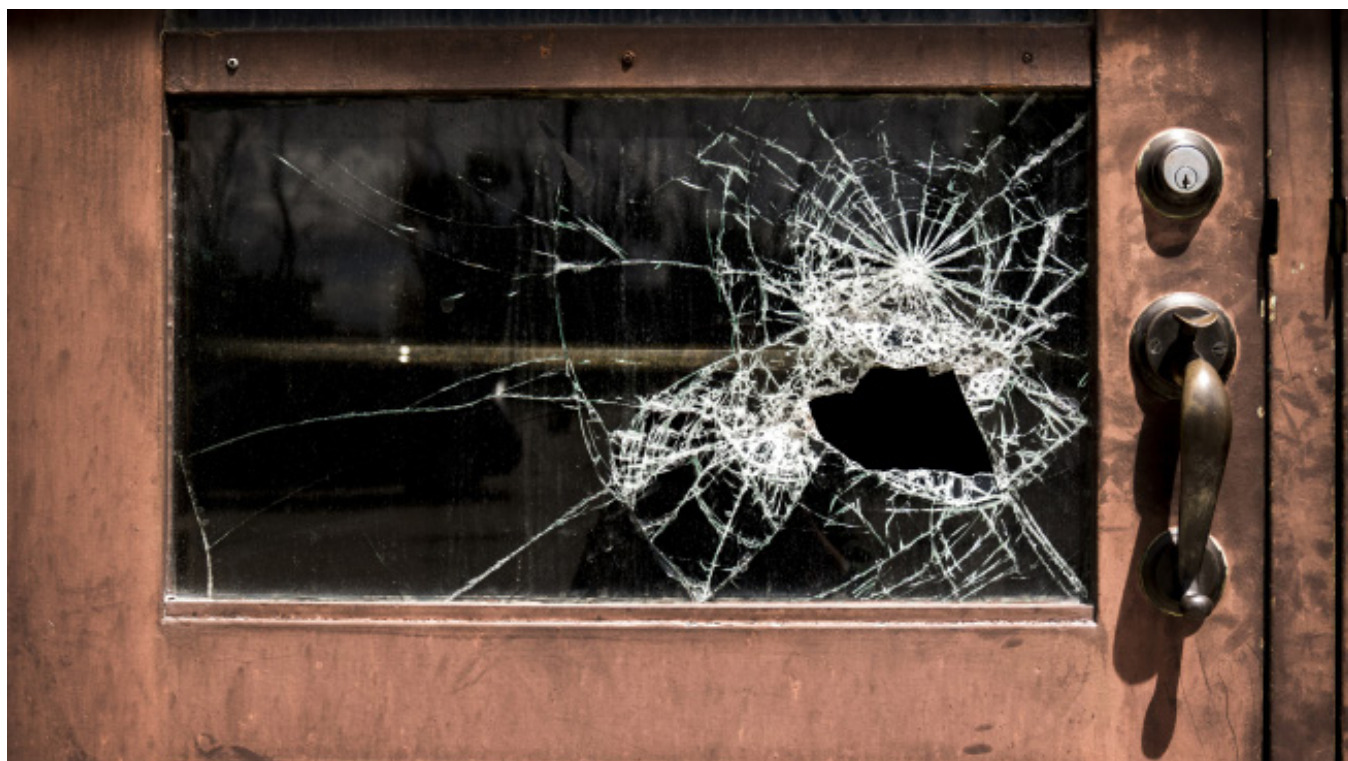
NEIGHBORHOOD SAFETY

Figure 105

Had felt their neighborhood was unsafe



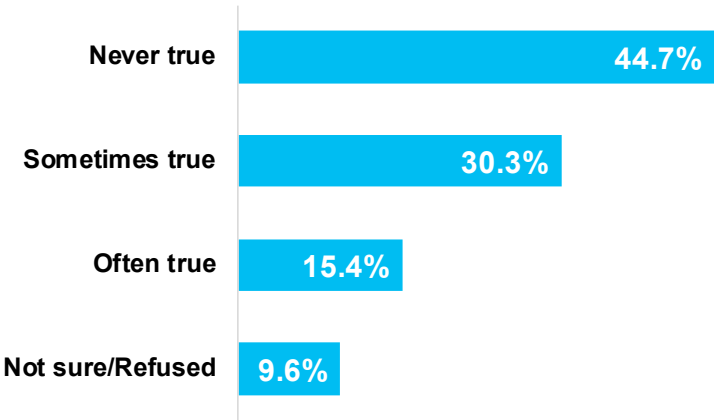
Of the 2,209 respondents, 19.0% said their neighborhood felt unsafe or extremely unsafe.



NUTRITION AND BALANCED MEALS

Figure 106

Was not able to afford to eat a balanced meal

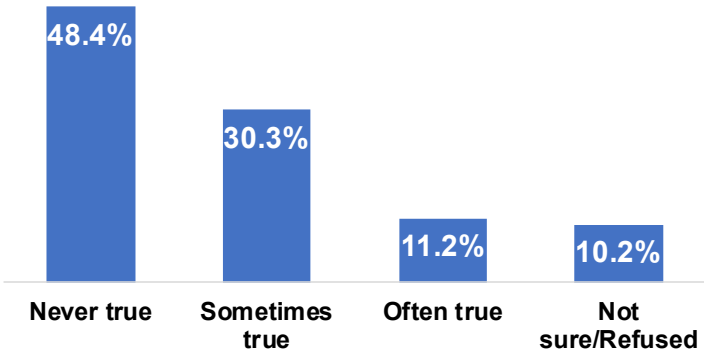


Of the 2,209 respondents, 45.7% agreed with the statement: that they were not always able to afford a balanced meal.

FOOD ACCESS

Figure 107

Was not able to buy more food due to cost in the past 12 months



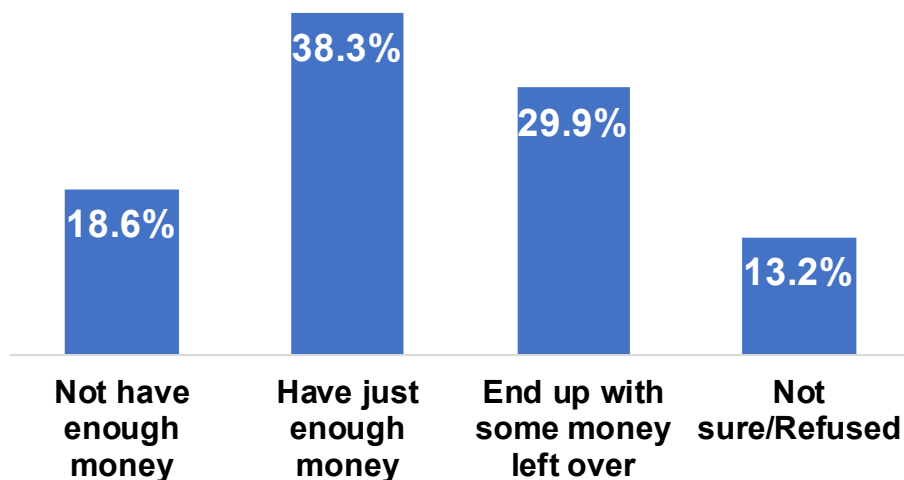
Of the 2,209 respondents, 41.5% agreed with the statements that they were not able to buy more food due to cost.



FINANCES

Figure 108

Finances at the end of the month

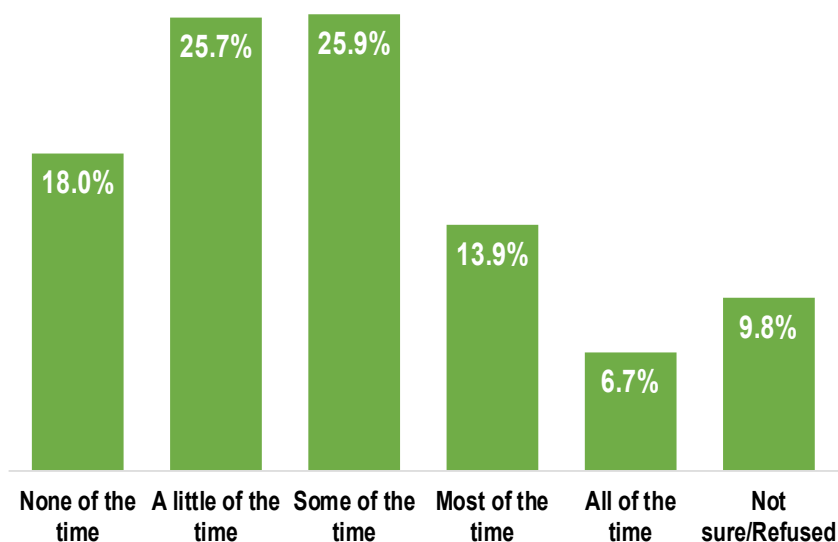


Of the 2,209 respondents, 18.6% answered they did not have enough money at the end of the month.

MENTAL HEALTH AND STRESS

Figure 109

Stress frequency in the past 30 days



Of the 2,209 respondents, more than twenty percent reported that they felt stress most or all of the time in the past 30 days.

Nutrition



NUTRITION

According to the CDC, poor nutrition contributes to costly diseases such as obesity, heart disease, and some cancers.⁷ Having healthy, affordable, and accessible foods can help support individuals in making healthy choices. One way of improving nutritional intake is to reclaim traditional diet and traditional ways.

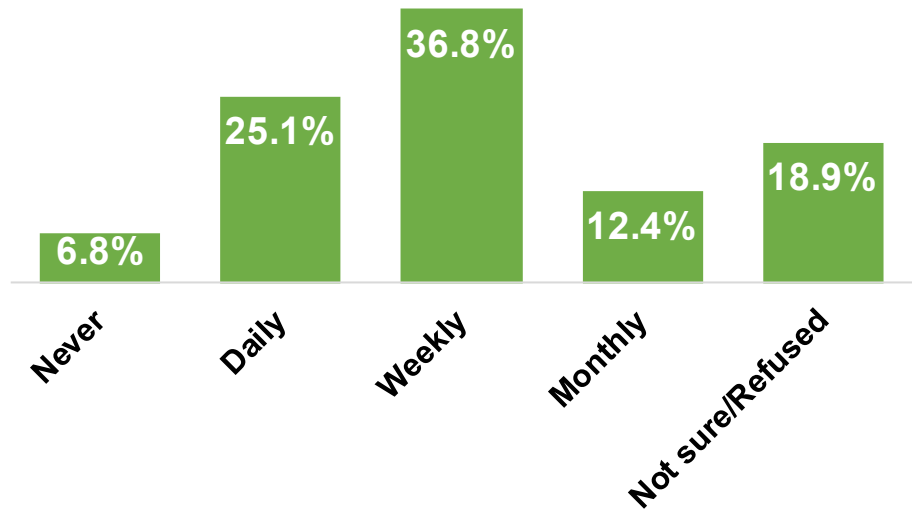
Reclaiming traditional foods supports a healthy diet and way of life and helps keep current and future generations healthy. Eating a diet filled with fruits and vegetables can help protect against chronic diseases, including heart disease, type 2 diabetes, some cancers, and obesity.²⁵



NUTRITION AND GREENS

Figure 110

Had eaten a green leafy or lettuce salad, with or without other vegetables

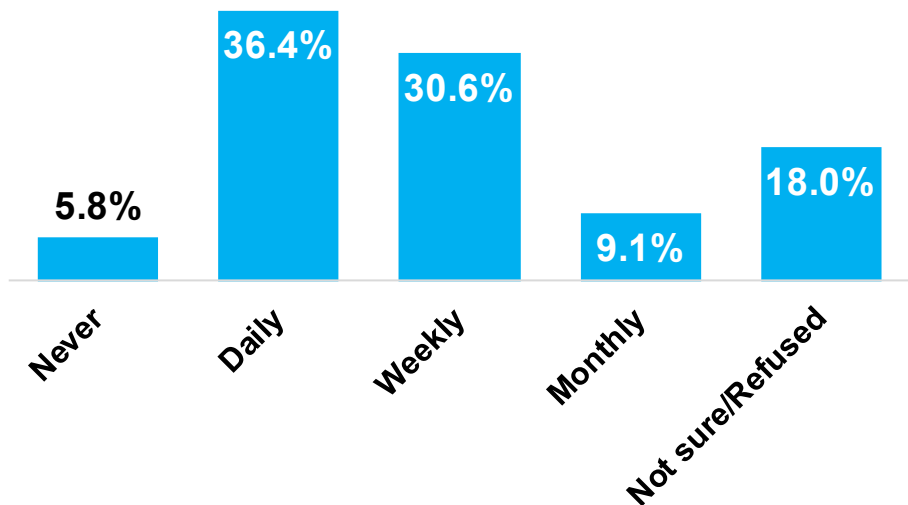


Of the 2,209 respondents, 36.8% answered that they ate greens weekly, followed by those that ate greens daily (25.1%).

NUTRITION AND FRUITS

Figure 111

Had eaten fruit

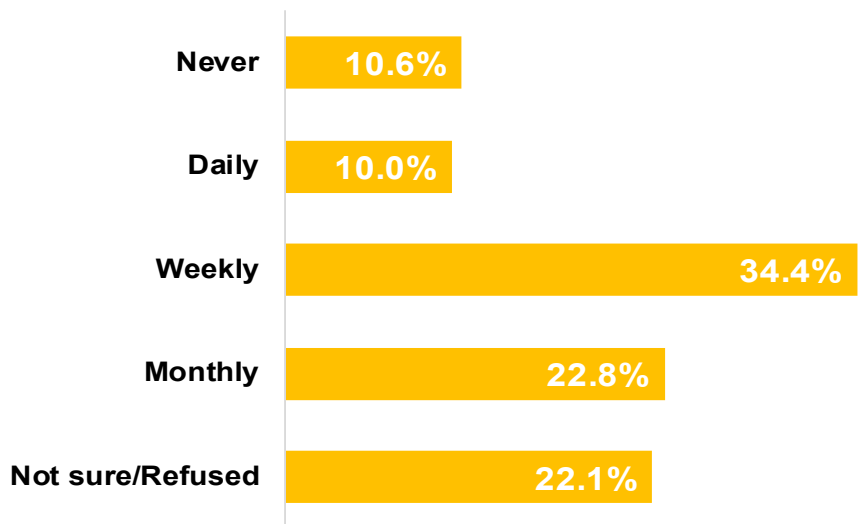


Of the 2,209 respondents, about thirty percent of respondents said they ate fruit (not including juice) at least daily or weekly.

NUTRITION AND OTHER POTATOES

Figure 112

Had eaten other kinds potatoes or sweet potatoes

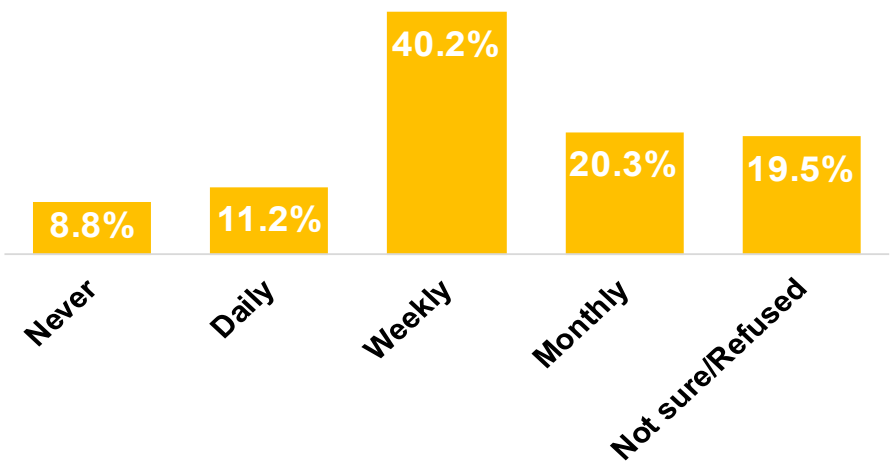


Of the 2,209 respondents, 34.4% said they ate other kinds of potatoes or sweet potatoes (i.e., baked, boiled, mashed potatoes, potato salad) weekly, followed by those who ate other potatoes monthly (22.8%).

NUTRITION AND FRIED POTATOES

Figure 113

Ate any kind of fried potatoes



Of the 2,209 respondents, about forty percent said they ate some kind of potato (fried potatoes, including French fries, home fries, or hash browns) weekly, followed by those who ate potatoes monthly (20.3%).

PHYSICAL ACTIVITY

Physical activity or exercise is a health behavior that supports physical and mental health. Regular physical activity helps to improve muscle strength, supports endurance, can prevent or delay chronic health conditions, decrease the risk for anxiety and depression, and support overall health and well-being.

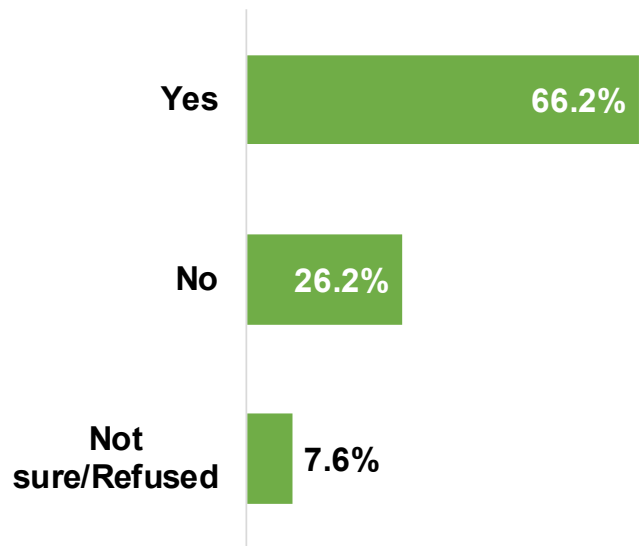
People who are active live longer and report improved quality of life. The CDC recommends 150 minutes of physical activity weekly, or 30 minutes a day, 5-days per week. Physical activity is anything that gets the body moving. It is recommended that adults do two types of physical activity each week to strengthen muscles and improve health-aerobic activity.²⁶



EXERCISE

Figure 114

Had participated in physical activities or exercises

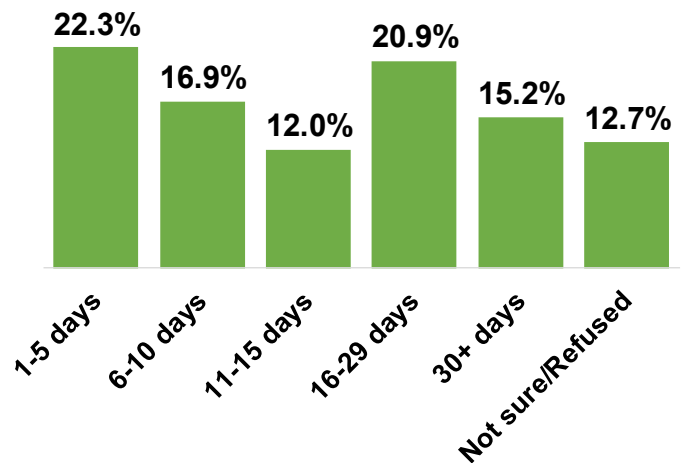


Of the 2,209 respondents, 26.2% reported that they had not participated in physical activity or exercise in the past month.

EXERCISE BY MONTH

Figure 115

Had exercised in past month



Of the 1,265 respondents that said they exercised during the past month, 28.5% reported that they engaged in physical activities between six and 15 days. The most common form of exercises included walking or running, weights, going to the gym, bicycling swimming, cardio, and yoga.

IMMUNIZATIONS

Adults need to keep their vaccinations up to date because immunity from childhood vaccines can wear off over time. Therefore, additional vaccine doses (boosters) may be necessary to maintain protection. Vaccination is one of the most convenient and safest preventive care measures available.²⁷

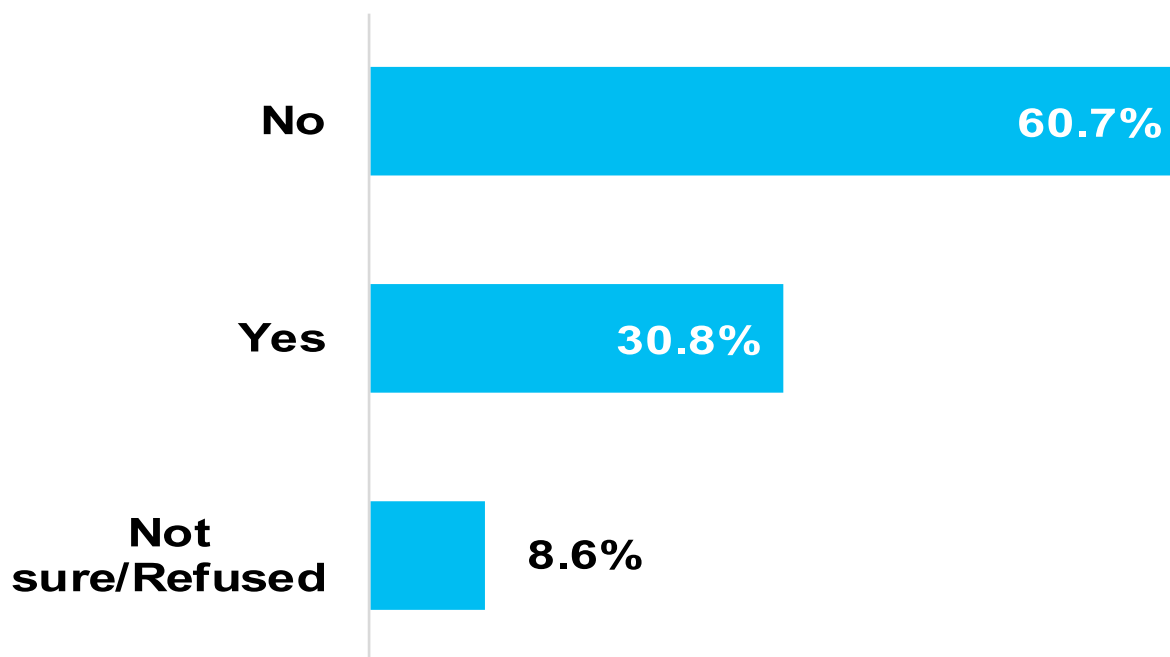
Receiving immunizations is one of the most effective preventative measures for disease according to the CDC. A 2016 study found that AIAN adults were 10% less likely to receive flu shots compared to non-Hispanics in the past 12 months.²⁸



RECEIVED INFLUENZA VACCINE

Figure 115

Received their influenza vaccine

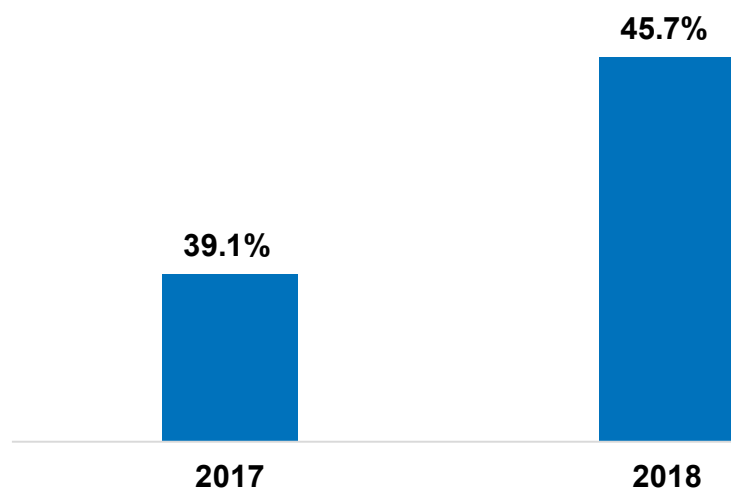


Of the 2,209 respondents, 30.8% said they received their influenza vaccine.

FLU SHOT BY YEAR

Figure 117

Had received the flu shot by year

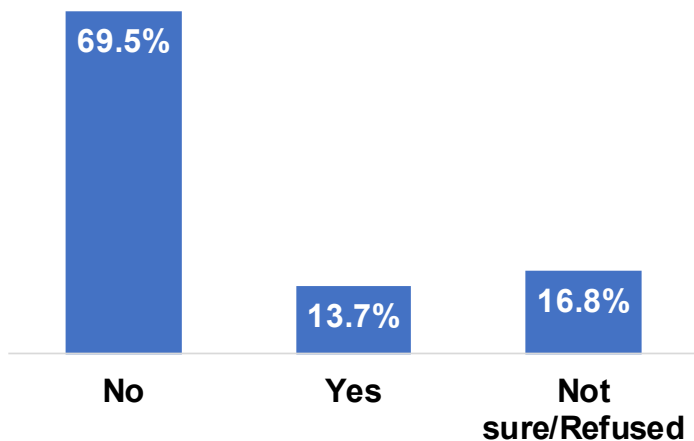


There was a higher percentage of respondents who got their influenza vaccination in 2018 (45.7%) compared to 2017 (39.1%), out of the 660 respondents.

SHINGLES OR ZOSTER VACCINE

Figure 118

Had received the shingles or zoster vaccine

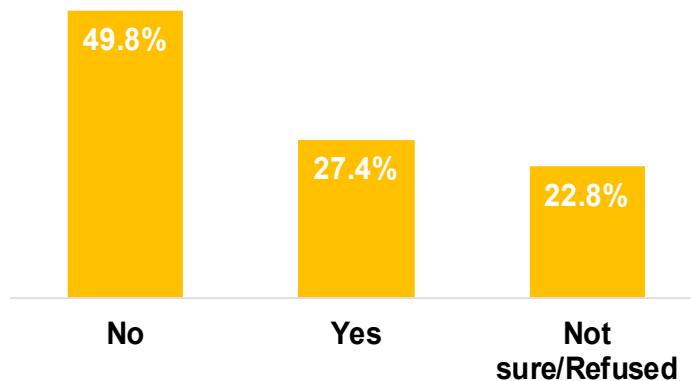


Of the 2,209 respondents, 13.7% said they had received the shingles or zoster vaccine.

PNEUMOCOCCAL VACCINE

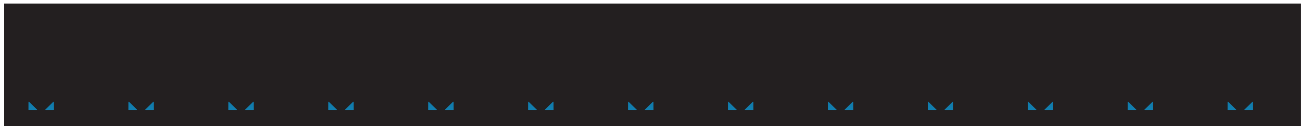
Figure 119

Had received the pneumonia shot or pneumococcal vaccine



Of the 2,209 respondents, 27.4% had received the pneumococcal immunization.

Spiritual Health and Cultural Connectedness



SPIRITUAL HEALTH AND CULTURAL CONNECTEDNESS

Research has found that high levels of cultural engagement including language use, traditional practices, cultural gatherings, and activities are associated with protective health behaviors. Cultural connectedness is a multi-level protective factor, positively influencing in the individual, relationship, and community level.

Healthy spirit is the foundation to achieving a healthy body, mind, and community. Traditional AIANs and health experts agree that spirituality can greatly impact numerous health problems. A person with a healthy spirit can connect themselves to the physical world and to beings beyond themselves. A healthy spirit, therefore, contributes to a greater sense of purpose and connection in life.

Allowing individuals to draw strength in order to live balanced and well-nourished lives. California Tribes have great richness and diversity leading to variation in how each Tribe practices spirituality. Although each Tribal nation has specific spiritual practices, there is a common foundation among them. This foundation is based on creation stories, ceremonies, traditional foods, and language. California Tribes have a strong connection to their homelands.

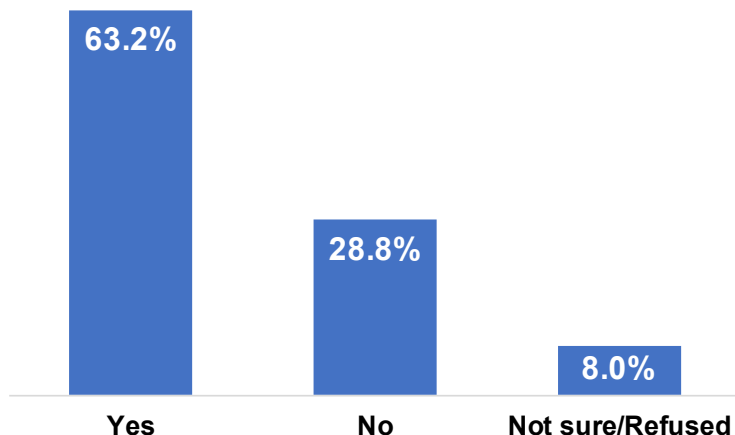
Many Tribes have genesis stories that are tied to specific and identifiable places. In general, traditional AIANs believe they do not own the land, but are responsible for taking care of and deriving sustenance from the earth. Overall, the various practices of California AIANs reveal a united worldview of the sacred and secular, of what is seen and unseen, all of which affects health and wellness.²⁹



ADVICE

Figure 120

Had a traditional person, such as an elder, or other person who they can talk to

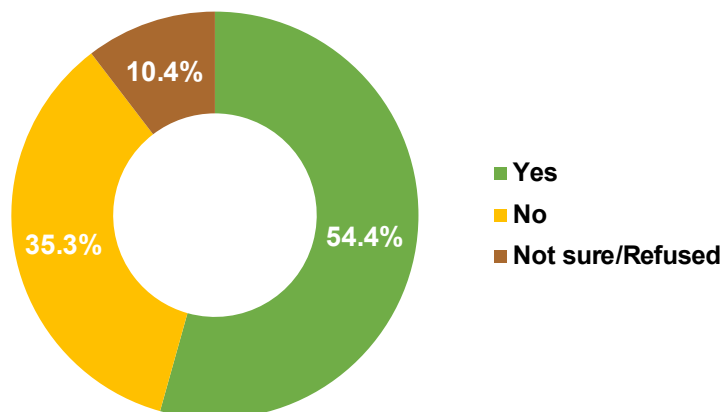


Of the 2,209 respondents, more than 60% of the total respondents reported they had a traditional person, Elder or other person they could talk to.

CEREMONIAL

Figure 121

Had used ceremonial/traditional medicines or guidance or prayer or other reasons

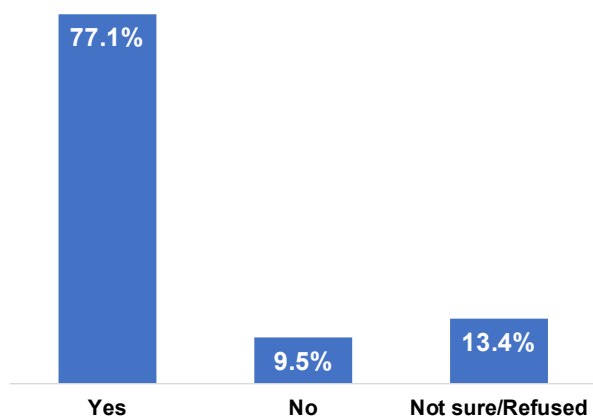


Of the 2,209 respondents, nearly 50% of the survey population used ceremonial/traditional medicines for guidance or prayer.

BELIEF IN NATURE

Figure 122

Had believed that things like animals, rocks (and all nature) have a spirit like AIAN



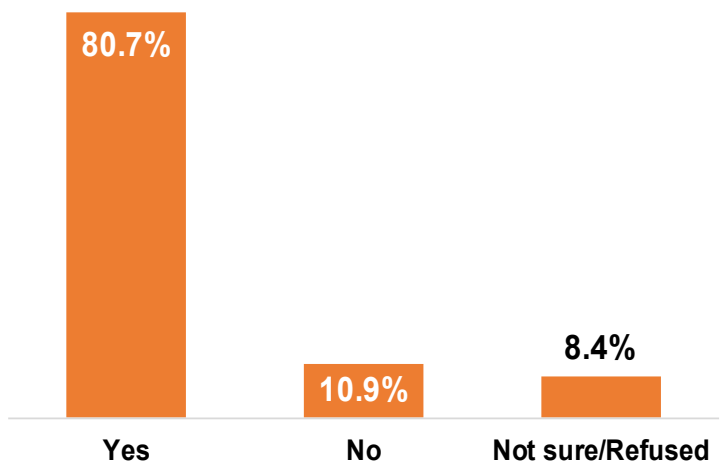
Of the 2,209 respondents, 77.1%, answered they believed that things like animals, rocks (and all nature) have a spirit like AIAN.



PLANNING AND CULTURE

Figure 123

Had planned on trying to find out more about their Native American/Indigenous culture



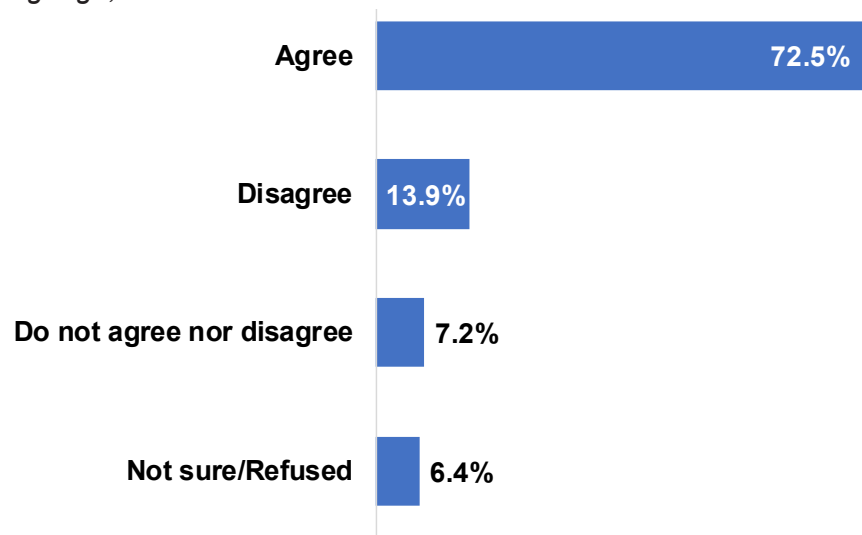
Of the 2,209 respondents, almost all respondents reported that they plan to find out more about their culture and history.



TIME LEARNING ABOUT CULTURE

Figure 124

Had tried to find out more about being Native American/Indigenous, such as history, Tribal identity, traditions, language, and customs

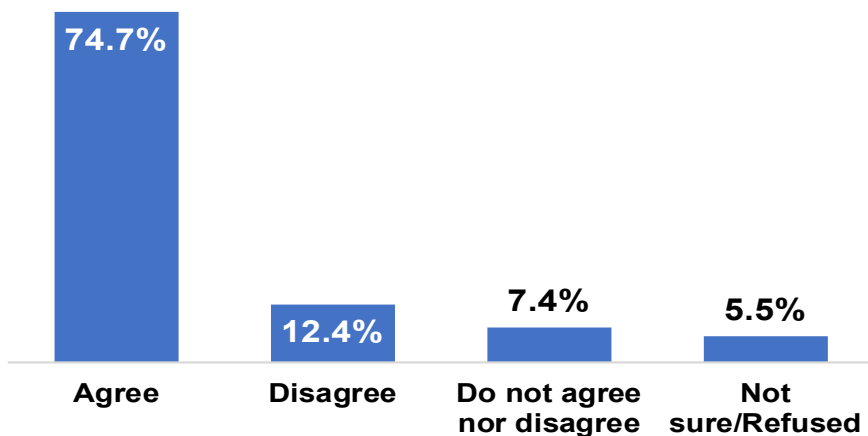


Of the 2,209 respondents, 72.5% reported they had spent time trying to find out more about being Native American/Indigenous, such as history, Tribal identity, traditions, language, and customs.

CONNECTION TO TRIBE

Figure 125

Had felt a strong connection/attachment to their Native American community or Tribe

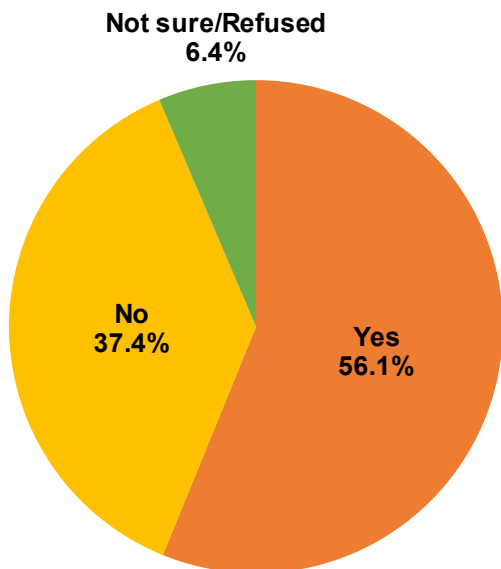


Of the total respondents, 74.7% agreed they had a strong connection to their Native American/Indigenous community or Tribe.

TRADITIONAL FOODS

Figure 126

Had consumed, prepared and/or gathered traditional foods

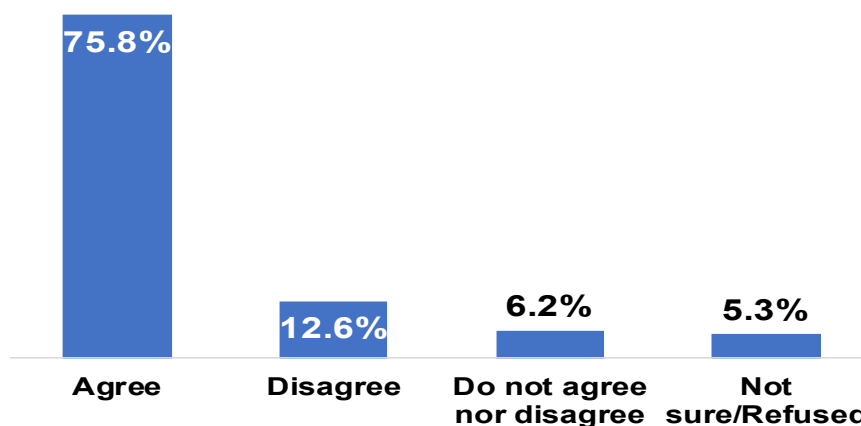


About 50% of the 2,209 respondents said they consumed, prepared and/or gathered traditional foods.

SENSE OF BELONGING

Figure 127

Has a strong sense of belonging to their Native American/Indigenous community or Tribal Nation

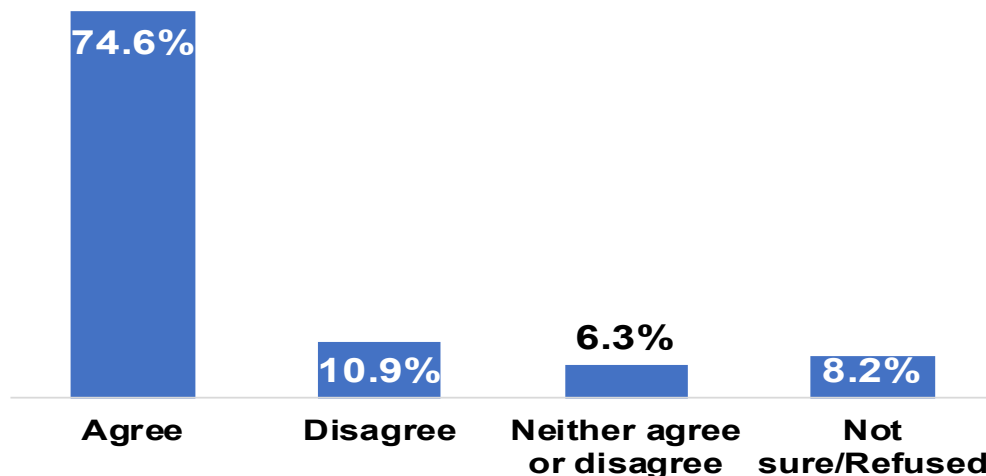


More than half of the 2,209 respondents agreed (75.8%) they had a strong sense of belonging to their Native American/Indigenous community or Tribal Nation, while only 12.6% said they disagreed. Only 6.2% said they did not agree or disagree with their sense of belonging.

SIGNIFICANCE OF FEATHERS

Figure 128

The eagle feather (or other feathers) has a lot of traditional meaning

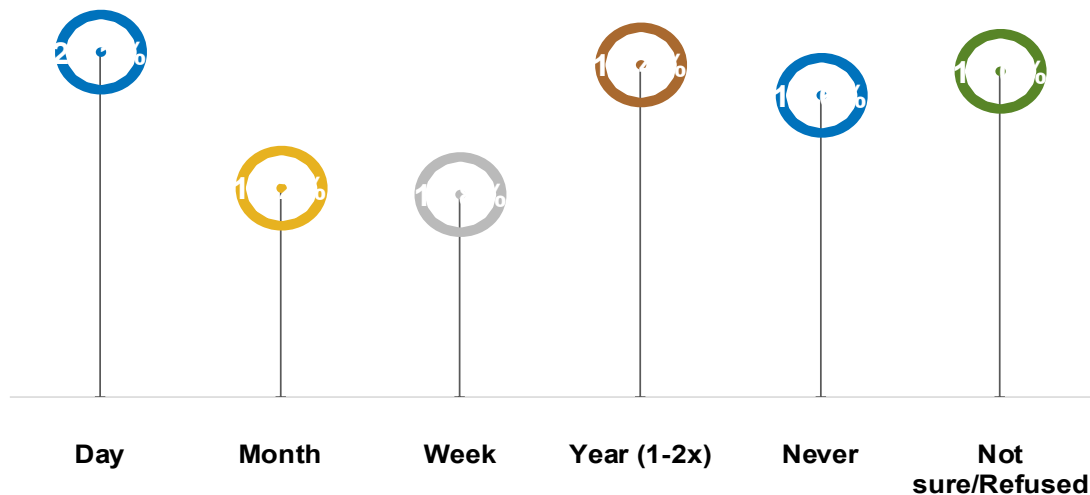


Of the 2,209 respondents (74.6%) agreed that the eagle feather (or other feathers) have a lot of traditional meaning to them, while 10.9% disagreed.

FAMILY AND CEREMONIAL TRADITION

Figure 129

Has a family member or a close person that uses ceremonial/traditional medicine



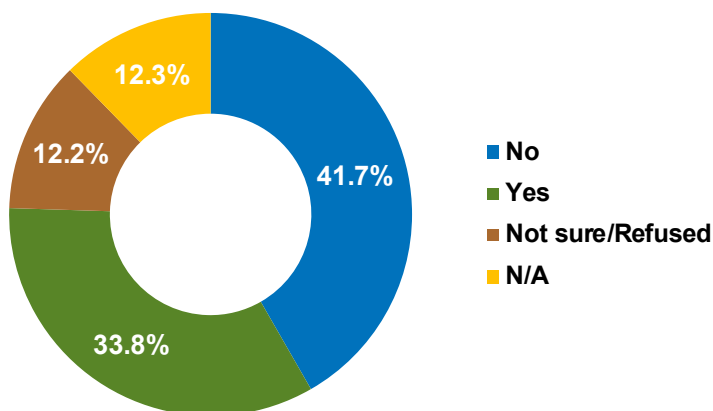
Of the 2,209 respondents, respondent's family members used ceremonial/traditional medicine at least once per day (20.1%), closely followed by those who used traditional medicine at least 1-2 times in the past year (19.4%), then by those who did not use ceremonial medicines (17.6%).



TRADITIONAL AIAN NAME

Figure 130

Respondents reported knowing if they have or do not have a traditional AIAN name



Of the 2,209 respondents, 41.7% reported they had a traditional AIAN name.

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Emotional and Mental Health



EMOTIONAL AND MENTAL HEALTH

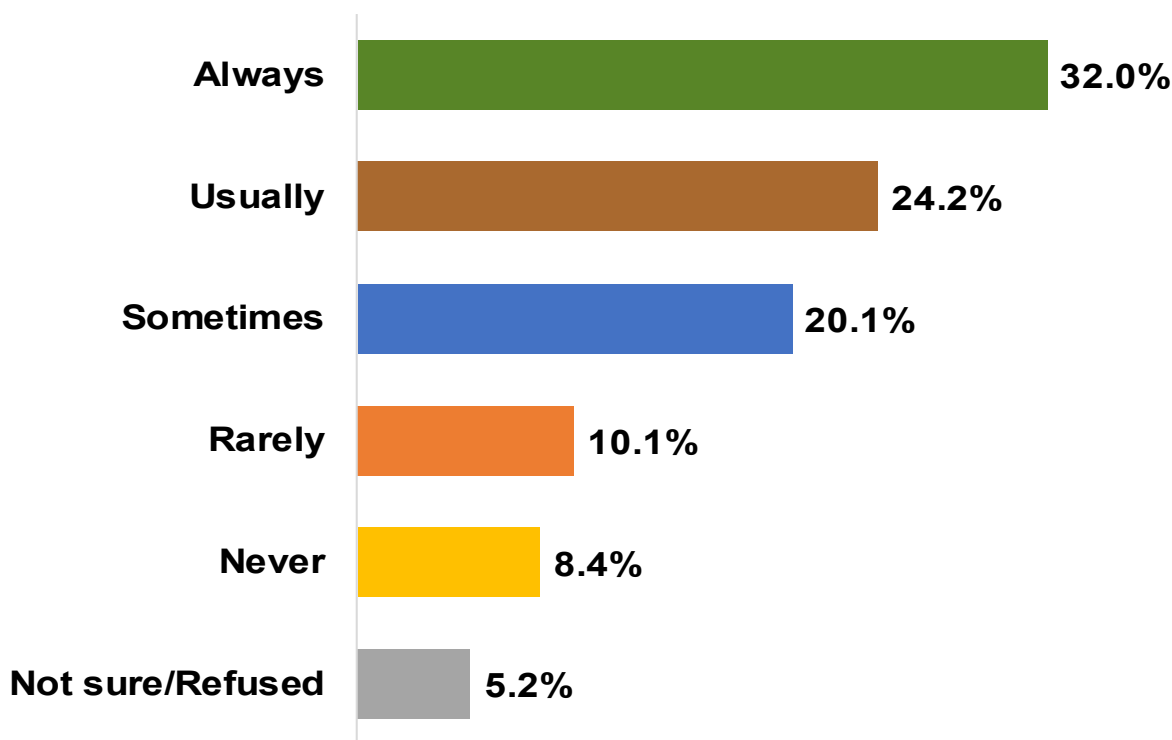
Mental health is an essential part of overall health and well-being and encompasses emotional, psychological, and social well-being. Mental health can be directly impacted and have a direct impact on health behaviors as it influences our thoughts, feelings, and actions. Additionally, it can influence resilience, coping, self-esteem, ability to relate to others, engage and adhere to healthy behaviors.

An individual can experience poor mental health but not be diagnosed with a mental illness. Similarly, a person with a mental illness can experience physical, mental, and social well-being. The relationship between physical and mental health is interconnected. For example, a mental illness can increase an individual's risk for many types of physical health problems. While a physical health problem such as chronic conditions, can impact an individual's mental health.³⁰

MENTAL HEALTH AND EMOTIONAL SUPPORT

Figure 131

Social and emotional support

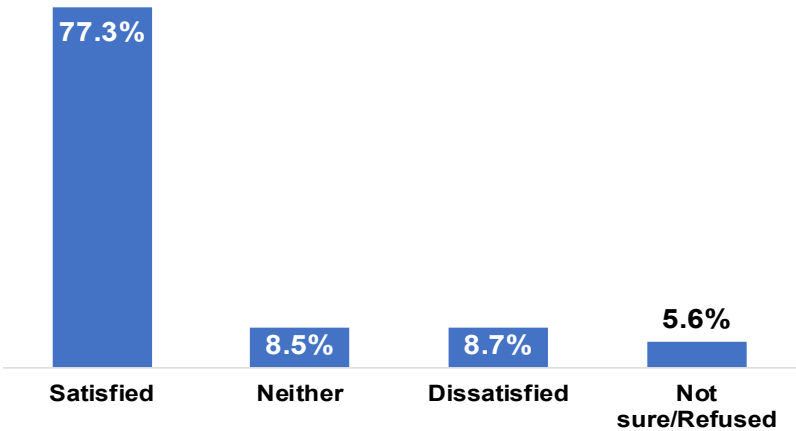


Of the 2,205 respondents, 62.8% said they do not always get the social and emotional support they need (missing = 4).

LIFE SATISFACTION

Figure 132

Life satisfaction



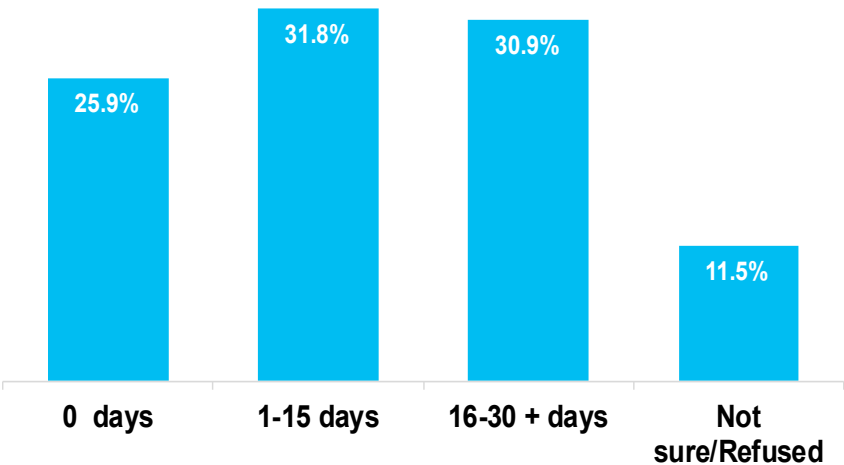
The majority of 2,209 respondents were satisfied with their life (77.3%), while 8.5% were neither satisfied nor dissatisfied with their life and 8.7% were dissatisfied with their life.



DAYS OF MENTAL HEALTH

Figure 133

Mental health status



Of the 2,209 respondents to the survey, 31.8% said their mental health was not good between one and 15 days, while 30.9% reported poor mental health for 16 or more days.



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Adverse Childhood Experiences



ACE

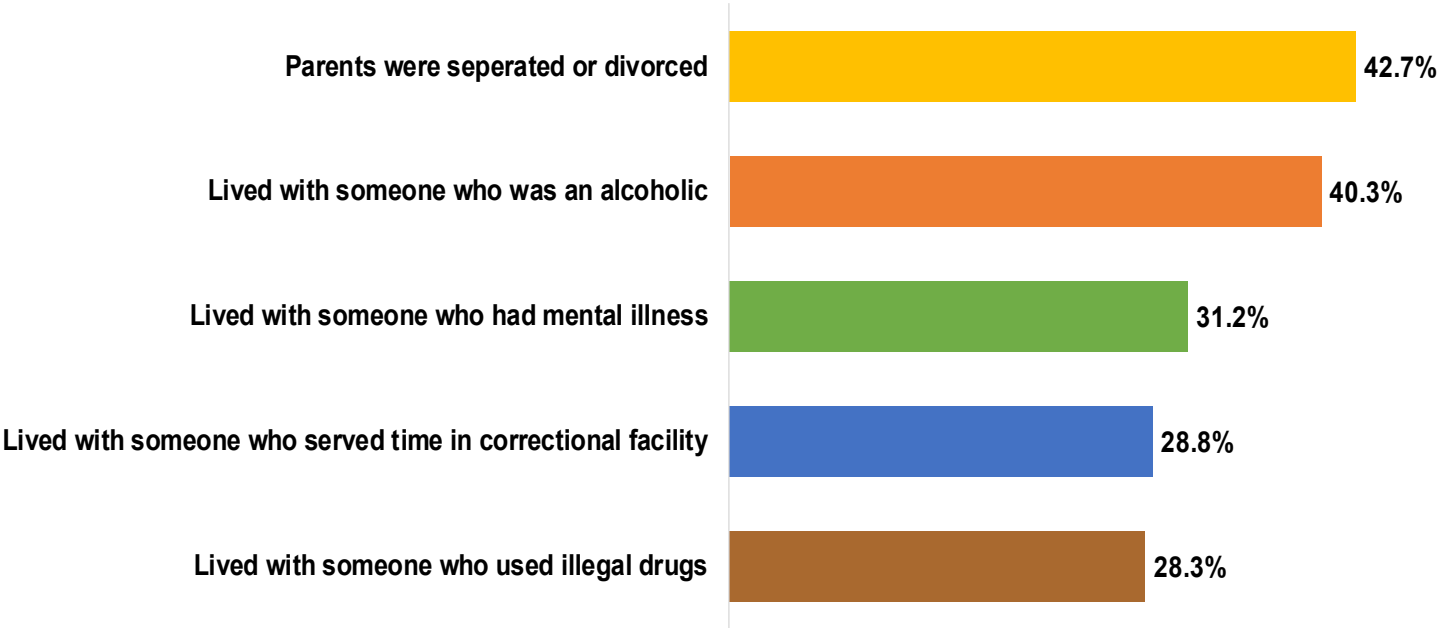
The objective of the ACEs study is to increase awareness among selected IHPs. This is important because the effects of ACEs can negatively impact the quality of life and have detrimental impacts on the health and well-being of those children during adulthood.

Nearly two-thirds of the general population report experience at least one ACE, such as loss of a parent, abuse, or domestic violence. Members of marginalized populations, including low-income and ethnic minority youth, are even at a greater risk of experiencing ACEs and consequently have been linked to an increase in poor health outcomes during adulthood. ^{31 - 35}

ACE AND EMOTIONAL TRAUMA THROUGH ABUSE

Figure 134

Experienced ACE through trauma through divorce, domestic violence, incarceration alcoholism or drug abuse

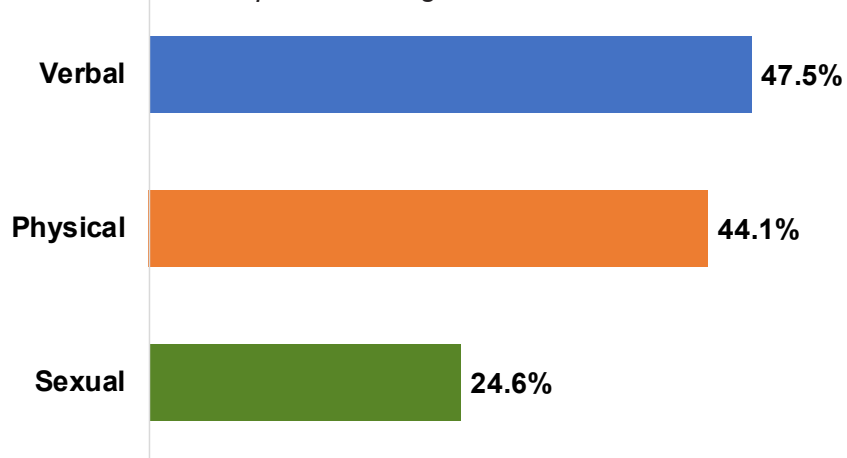


ACE survey results show that among all respondents, 42.7% had parents who were separated or divorced, and 40.3% who lived with someone who was an alcoholic.

ACES AND SEXUAL ABUSE

Figure 135

Experienced sexual abuse prior to the age of 18



Among the 2,209 respondents, 47.5% experienced verbal abuse, 44.1% experienced some type of physical abuse, and 24.6% experienced some type of sexual trauma.



KEY FINDINGS

Results from this cross-sectional study showed that 2,209 AIAN adults completed the survey. Of the total respondents, 46.6% were between 18 and 40 years of age, 65.2% were female and 47.6% identified as AIAN only. Of those that identified with another race (in addition to AIAN), 62.6% were AIAN and White (non-Hispanic). Of the respondents, 48.6% were enrolled in a federally recognized Tribe in California. Approximately one-third of respondents were single and another one-third were married. Only 15.7% graduated from college or completed graduate school. Almost 50% were employed for wages. Twenty percent of respondents said they made less than \$10,000 a year and 12.5% said they made between \$35,000-\$49,000.

The health status analyses showed that almost thirty percent of the total survey population had not had a routine check-up in over a year. Less than five percent reported that their health status was poor. Approximately thirteen percent of respondents did not have health coverage. According to their body mass index, most respondents were either considered to be in the obese category (54.7%) or overweight (29.3%). Over half of the survey population for each type did not receive a flu vaccination, shingles, zoster, or pneumococcal vaccine. About half of the respondents had been tested for the human immunodeficiency virus (HIV), and almost all said they had not been treated for a sexually transmitted disease in the past year.

Respondents with high blood pressure were advised by their medical providers to change their lifestyles. These changes included altering their diets (69.7%) or taking medications (58.0%). About twenty percent of the respondents were diagnosed with diabetes by a health professional. Of those diagnosed with diabetes, about fifty percent were between 31 and 50 years of age when first diagnosed with diabetes.

The analysis showed that there was alcohol and drug use among the survey population. Almost 70% had an alcoholic drink in the past month. Among those, 37.8% binge drank. Among females, 35.2% binge drank (four or more drinks on a single occasion) in the past month. The percentage among males was 43.6% who binge drank (5 or more drinks on a single occasion). About one-fourth of the respondents reported using illegal or prescription drugs for non-medical reasons in the past year. Of those who reported using marijuana or hashish, almost half used it 16 days or more in the past 30 days. Of those that reported smoking, nearly one-third smoked every day and two-thirds tried to quit.

Spiritual and cultural connectedness analyses showed that 80.7% of all respondents planned to learn more about their culture and history. Most respondents agreed (72.5%) that they had spent time trying to learn more about being Native American/Indigenous, such as history, Tribal identity, traditions, language, and customs. Of the total respondents, 74.7% agreed they had a strong connection to their AIAN/Indigenous community or Tribe. Most of the respondents (75.8%) agreed they had a strong sense of belonging to their Native American/Indigenous community or Tribal Nation. Only 12.6% disagreed with the statement about belonging.

Results from the analyses showed that 62.8% of the total respondents said they did not always receive the social and emotional support they needed. Some of the common adverse childhood experiences (ACE) included past parent separation/divorce (experienced by 42.7% of respondents) and living with someone who abused alcohol (40.3%). Results also found that 47.5% experienced verbal abuse, with about one-fourth reporting sexual abuse.

LIMITATIONS

A few caveats should be considered when reviewing the results of this report. Many respondents were recruited at AIAN community events or clinics, therefore, findings from the TBRFS may or may not be generalizable to those who do not attend these types of events. In addition, since all responses were self-reported, there may have been recall bias. Although the data needs to be more comprehensive in generalizability, it remains an important source of information on the health and well-being of the AIAN population in California.

NEXT STEPS

Further studies should be conducted on chronic diseases, alcoholism, smoking, and ACE. Results from this report can be utilized by Tribes, THPs, and UIHPs to bolster advocacy and policy-making decisions, monitor progress toward achieving physical and mental health objectives and improve disease prevention programs to decrease health risk behaviors in California AIANs.

APPENDIX





KEYWORDS

Demographic information: refers to statistics that describe a population and can be used to divide that population into different groups. Examples include: age, gender, race, income, marital status, employment status, nationality, and political preference.

Descriptive statistics: a term given to the analysis of data that helps describe, show, or summarize data in a meaningful way. They DO NOT, however, allow us to make conclusions beyond the data we have analyzed or reach conclusions regarding any hypotheses we have made.

Ethnicity: a social group characterized by a distinctive social and cultural tradition, maintained within the group from generation to generation, a common history and origin; and a sense of identification with the group. Members of the group have distinctive features in their way of life, shared experiences, and often a common genetic heritage (Last, 2001). (See all Race)

Health: a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Health indicator: a measure that reflects, or indicates, the state of health of persons in a defined population, e.g., the infant mortality rate.

Mean: the average. It is calculated by adding together all the individual values in a group of measurements and dividing by the number of values in the group.

Median: the measure of central location which divides a set of data into two equal parts.

Prevalence: refers to proportion of persons who have a condition at or during a particular time period, whereas incidence refers to the proportion or rate of persons who develop a condition during a particular time period.

Race: a term that refers to having distinct physical characteristics. Biologic classification of human races is difficult because of significant genetic overlaps among population groups. Social scientists have challenged the biologic definition of race, arguing that the concept of race most often reflects social and ideological conventions. However, race is a useful concept from the public health perspective because some diseases are strongly correlated with race (Last, 2001)

Rate: an expression of the frequency with which an event occurs in a defined population.

For additional terms, please refer to the CDC's Epidemiology Glossary at https://www.cdc.gov/reproductivehealth/data_stats/glossary.html

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CALIFORNIA HEALTH PRIORITIES

In 2017, the California Tribal Epidemiology Center conducted a Health Priorities Survey to identify the top 10 health priorities for the California Tribal community. A total of 1,404 adults participated in the Health Priorities Survey throughout California and identified the following Health Priorities for the California Tribal community in order of importance:

1. Diabetes
2. Alcohol/Substance Abuse
3. Obesity
4. Mental/Emotional Health Issues
5. High Blood Pressure
6. Limited Access to Medical Care
7. Chronic pain
8. Other (e.g., cancer and access-related health issues)
9. Heart Disease
10. Suicide

The California identified health priorities are highlighted throughout the report and comparisons are made with available statewide data from CDC's 2018 BRFSS data for California. Eight of the ten specific health priorities have data represented in the Tribal Behavioral Risk Factor Surveillance Report. The two health priorities that are not specific to the report are suicide and chronic pain. While there are indicators for mental/emotional health relevant to increased suicide risk, the data is not suicide specific. The same applies to chronic pain, while there are specific questions on chronic pain for individuals diagnosed with arthritis, there are no general questions to chronic pain.

EXAMPLE LISTS

Cultural Connectivity Scale – Urban California

[REV JAN 2017]

List 1: Ceremonial & Traditional Medicines • Angelica Root • Bear Root • Cedar • Corn Pollen • Copal • Greasewood • Jimson • Milk Weed • Mountain Tea • Mugwort • Palo de Santo, • Peyote • Sage • Sweetgrass • Tobacco • Women's Tea	List 2: Uses of Ceremonial & Traditional Medicines • Asking for a blessing in a sacred manner, • Calmness • Cultural connections • Gifting to show respect • Give thanks • Guidance • Help Sleeping • To honor • Personal Healing • Prayer • Smudge • Spiritual connections • Spiritual Offerings • Steady Mind • Talk to the creator • Keep bad spirits away	List 3: Traditional, Tribal & Cultural Ceremonies or Activities • Acom Ceremony • Beading Class • Bear Dance, Sun Dance, Round Dance or other Cultural Dance • Big Time • Burning of Clothes • Coming of Age • Deer Gathering • Drumming • Feast Giveaway • Fiesta (South of Kern Valley) • GONA • Longhouse • Moon Ceremony • New Years • Pot Latch • Pow Wow • Puberty Ceremony • Repatriation • Running is my High • Spring Ceremony • Story Telling • Sunrise Ceremony • Sun Rise (Alcalraz) • Sweat Lodge • Traditional Tattoo • Washing of the Face • Wiping of Tears • Young Men's Ceremony • Yuwipi	List 4: Cultural Uses of Food • Spirit Plate • Thank You Ceremony • Special Feast • Community Feed • Other,....	List 5: Traditional Persons, Elders & Leaders • Ceremonial Leader • Cultural Teacher • Doctor • Elder • Father • Feather Man • Feather Woman • God Father • God Mother • Head Heir • Head Man • Head Woman • Medicine People • Mother • Mother Bear • Regalia Leader • Spiritual Person • Timiwal • Top Doc
List 6: Types of Feathers • Condor • Eagle Feather • Flicker • Hawk • Humming Bird • Quail • Raven • Turkey • Wood Pecker				

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